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ABSTRACT

This report analyzes HEW's resource distribution in terms of rural development activities via a program by program examination of the distribution of funds for fiscal year 1972. For programs where data are available for obligations in fiscal years 1970 and 1972, comparisons which highlight significant changes and identify possible change agents are presented. Program analyses are presented for the following areas: (1) Public Health Service; (2) Education Division; (3) Office of the Secretary; (4) Social and Rehabilitation Services; (5) Social Security Administration; (6) Programs jointly funded or administered by HEW (Appalachian Regional Commission, Comprehensive Employment and Training Act, and Concerted Services in Training and Education). Representative of the significant 1972 statistics cited are: (1) of the $70.4 billion of HEW 1972 funds, 35 percent went to rural areas; (2) of the $48.3 billion HEW Social Security funds, 37 percent went to rural areas; (3) of the $23.4 billion HEW Social and Rehabilitation Service funds, $4.5 billion went to rural areas; (4) of the $4.9 billion HEW Office of Education funds, 31 percent went to rural areas; (5) of the $1.5 billion HEW Health Services and Mental Health Administration funds, 27 percent went to rural areas. (JC)

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Department of Health, Education, and Welfare Program Assistance for Nonmetropolitan Areas

Fiscal Year 1972

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FOR THE

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OF THE

COMMITTEE ON AGRICULTURE AND FORESTRY

UNITED STATES SENATE

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CHAPTER I

INTRODUCTION

The report contained herein was prepared in response to a request from the Subcommittee on Rural Development of the Senate Committee on Agriculture and Forestry. During the Department's testimony at the quarterly oversight hearings on the Rural Development Act of 1972, which were held in July 1973, questions were raised regarding the Department's resources available for rural development activities. Since HEW has no programs specifically designed for rural areas but rather directs its resources toward individuals whose needs are determined primarily by income criteria, the best way the Department can respond to such a question is through a program by program examination of its distribution of funds during a given period of time.

Such a study was performed by the Department in 1971 for the Senate Committee on Government Operations and was published by that committee under the title, "The Economic and Social Condition of Rural America in the 1970's: Impact of Department of Health, Education, and Welfare Programs on Nonmetropolitan Areas." Based on fiscal year 1970 data, the report analyzed the distribution of the Department's program obligations between metropolitan and nonmetropolitan counties and attempted to identify reasons for apparent imbalances in specific program obligations.

The present report is essentially an update of the previous one. While most of the data presented are for fiscal year 1972, the study describes the Department's programs as they were in that year and cites changes which have occurred since then. Because there have been some administrative reorganizations since the first study was completed, these are discussed in the introductory section of each chapter. For programs where data was available for obligations in fiscal years 1970 and 1972, comparisons have been made in terms of the percentages of total program funds allocated to metropolitan and nonmetropolitan areas. In those instances where there appeared to be significant changes between fiscal years 1970 and 1972 in the nonmetropolitan share of obligations, such changes have been highlighted, and factors which may have influenced the changes are identified.

The information contained herein represents one approach to describing HEW's program activities in nonmetropolitan areas. The report was prepared by the Department of Health, Education, and Welfare's Office of Rural Development in consultation with agency program managers, the Department's Data Management Center, and staff from the U.S. Department of Agriculture.

METHODOLOGY

Gathering information about HEW program operations and policies

When this study was initiated in August 1973, the most recent financial data available for analysis was for fiscal year 1972. In that year the Department had an appropriation and, therefore, new start money for programs. Although 1973 data became available in the fall of 1973, it was decided not to analyze that information since HEW's budget had been on a continuing resolution since July 1, 1972.

Information on program operations had been gathered for the fiscal year 1970 study through the use of a questionnaire. This method was not entirely satisfactory, however, and considerable follow-up work was required to complete individual program descriptions. For the present study it was decided to send the program description from the earlier report back to the administering agencies for verification and update. Although some additional research was required, the method proved satisfactory. Descriptions are provided for approximately 250 of the programs which were administered by the Department and which reported obligations for fiscal year 1972.

Gathering information about program obligations in nonmetropolitan areas

Information was collected on amounts of dollars obligated by each program to metropolitan and nonmetropolitan areas for fiscal year 1972. This was accomplished through the cooperation of the Data Management Center, Office of the Assistant Secretary, Comptroller, HEW, which provided access to the overall data, and from the Area Analysis Branch, Economic Research Service, USDA, which provided a breakdown by metropolitan/nonmetropolitan of the 3,141 counties in the United States.

Information by program on financial obligations in fiscal year 1972 was provided by the Data Management Center based on data routinely collected by the Comptroller according to procedures set forth in the Department's Accounting Manual, chapter 5–80, "Financial Assistance Reporting System." This is the same data collected for the purposes of meeting the requirements of Office of Management and Budget circular A–84.

With respect to the breakdown of U.S. counties into metropolitan/nonmetropolitan groups, the definition used for this study is the same as that for the fiscal year 1970 study—metropolitan being defined as all counties located in a standard metropolitan statistical area and having a population density greater than 100 persons per square mile, and nonmetropolitan being all counties not meeting the definition of metropolitan. According to this definition, in fiscal year 1972 there were 379 metropolitan and 2,762 nonmetropolitan counties.

Data on program obligations by county were then summarized by State as reported in the appendix, table 3.[1] State data were in turn summarized into national totals grouped according to major HEW administrating agencies. This information is provided in table 2 of the appendix.

It needs to be understood that, except where noted, all figures and percentages used in this report are for program *obligations* rather than *expenditures*. Data on the latter are generally not available until at least 2 years after the close of a fiscal year. In addition, there are factors which need to be understood with regard to how the data is collected by HEW. First, data provided in this report is, of course, only as accurate as the data submitted by individual agencies. Underreporting or inaccuracies by agencies in reporting their obligations may be reflected in the data maintained in the central record bank.

Second, a problem arises with some of the data in State-administered discretionary programs. Most programs of this nature are funded by the Office of Education and the Social and Rehabilitation Service. Funds are allocated to the State and are initially registered in the capital county in the HEW accounting system. Many of these programs have formulas—based on population, income, etc.—for the distribution of money within the State. For those State-administered programs which are not required to submit an annual audit to HEW, but whose fund distribution within the State is based on a formula, Data Management Center has devised a statistical formula for recording money obligated throughout the State. There are, however, certain programs, most notably vocational education, in which no formula is used, no annual State audit is required, and no statistical distribution methods have been devised to account for the distribution of the money beyond the capital county. As a result, most vocational educational data is subject to question. Most vocational education funds appear in the capital county, which is usually metropolitan. These figures, therefore, may distort the Office of Education total picture. Suffice it to say that the capital county problem in State-administered programs may skew the data somewhat.

Comparing and relating information on program operations and policies to data on program obligations

In order to relate data on program obligations to the descriptions of individual programs, it was necessary to match program titles as listed in the Office of Management and Budget *Catalog of Federal Domestic Assistance* with the titles of appropriation categories used in the financial assistance reporting system (FARS) listings used throughout the Government. From this process data on the distribution of obligated funds, expressed in dollars and percentages, was made available for inclusion in the individual program descriptions contained in chapters II to VII.

Comparing data on program obligations in nonmetropolitan areas from one fiscal year to another

The Office of Rural Development encountered some basic methodological problems in attempting to compare the nonmetropolitan shares of program obligations for the two years, fiscal years 1970 to 1972.

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[1] Information concerning table III can be obtained from the Senate Committee on Agriculture and Forestry, Room 322, Russell Senate Office Bldg.

It was thought at the outset that such an analysis would provide useful information on trends in the rural/urban distribution of HEW resources. As the study proceeded, however, it became apparent that several factors made such a departmentwide analysis quite difficult within the scope of study given the Office's resource constraints.

First, in many instances administrative reorganization made the task of finding comparable obligation figures for discrete programs or groups of closely related programs complex, and in several cases strictly comparable figures could not be determined. Second, over the 2-year period there were a number of changes in legislation or program regulations which made direct comparison of available data for fiscal years 1970 and 1972 inappropriate. Third, changes in data reporting requirements—specifically the deadline for submission—sent to administering agencies appeared to have affected the obligation totals for some programs, but not for others. Fourth, data on metropolitan/nonmetropolitan population distributions were used for analytic purposes in the fiscal year 1970 study. Comparable data for fiscal year 1972 were not available because of a change in the criteria used to define nonmetropolitan counties. Consequently, valid statements on trends in the distribution of obligations in comparison with population distributions could not be made. In view of these variables, analysis of changes in the distribution of obligations over the 2-year period for all programs administered by the Department was found to be well beyond the scope of study possible.

Reporting on departmental reorganization

Because numerous organizational changes have occurred within HEW since the initial study was published in 1971, information on these changes is provided in this report to facilitate the reader's understanding of where specific programs are currently administered in the Department. Serving as the introduction to each chapter as well as the beginning of each section on a major administrative unit, these statements on current organization are based on a comparative examination of the *U.S. Government Organization Manual* for the years 1970 and 1972—published by the National Archives and Records Service of the U.S. General Services Administration—Other sources of information on Departmental reorganization included "A Common Thread of Service, A Historical Guide to HEW" (U.S. Government Printing Office), selected articles from the *HEW Newsletter*, and agency specific documents from the Office of Rural Development files.

Financial data on appropriations, budgets, and obligations was assembled from several sources: "Impact of Department of Health, Education, and Welfare programs on nonmetropolitan areas; fiscal year 1970" (U.S. Senate Subcommittee on Government Operations), *Catalog of Federal Domestic Assistance*, editions for 1972, 1973, and 1974 (U.S. Office of Management and Budget), and information furnished by the HEW Data Management Center.

SUMMARY OF STATISTICS

HEW obligations in fiscal year 1972

Of the approximately $70.4 billion which HEW obligated for fiscal year 1972, 35 percent or about $24.7 billion was designated for nonmetropolitan areas. Comparing this with fiscal year 1970, the proportion of total obligations going to nonmetropolitan areas remained nearly constant, 36 percent in fiscal year 1970 and 35 percent in fiscal year 1972. At the same time, however, during the 2-year period total obligations to nonmetropolitan areas increased 36 percent while obligations to metropolitan areas increased 45 percent.

Agency obligations

The largest single category of obligations is the social security program which accounted for $48.3 billion, or 69 percent of the Department's total. In fiscal year 1972, 37 percent of social security funds ($18 million) was obligated to nonmetropolitan areas.

The Social and Rehabilitation Service obligations, which were primarily for income maintenance for the categorically needy, amounted in fiscal year 1972 to $23.4 billion, representing 19 percent of the HEW total. Rural areas received 34 percent, or $4.5 billion.

Of the remaining $2.2 billion in HEW nonmetropolitan obligations, 68 percent was obligated for Office of Education activities. Approximately 31 percent, or $1.5 billion of the Office of Education's total of $4.9 billion, went to rural areas. Office of Education obligations represented 7 percent of the Department's total obligations for fiscal year 1972.

Within the Public Health Service, the Health Services and Mental Health Administration obligated a total of $1.5 billion of which 27 percent, or $407 million, went to rural areas. The National Institutes of Health obligated $1.8 billion of which 10 percent ($120 million) went to nonmetropolitan areas. Altogether, the Public Health Service was responsible for total obligations amounting to $3.4 billion which represented 5 percent of HEW obligations in fiscal year 1972. It is worth noting that Public Health Service obligations to rural areas increased 71 percent from fiscal year 1970 to fiscal year 1972. Public Health Service obligations to urban areas increased 68 percent during that same period.

The Office of the Secretary had little program money in fiscal year 1972, and most of it was allocated for child development. Of the $0.3 billion total, 45 percent ($145 million) was obligated to nonmetropolitan areas. Compared with fiscal year 1970, Office of the Secretary obligations decreased roughly 20 percent and constituted one-half of 1 percent of total HEW obligations.

CHAPTER II

PUBLIC HEALTH SERVICE PROGRAM ANALYSES

Although the Public Health Service had its origin in 1798, it was the Public Health Service Act of 1944 that consolidated and revised existing legislation relating to the Public Health Service. Since then, numerous functions have been added such as: expanding grants to States for health services, financial assistance to health professions educational institutions, national health surveys, grants to State and local agencies for comprehensive health planning, and funds for research to improve the delivery of health services.

The major functions of the Public Health Service are: To stimulate and assist States and communities with the development of local health resources and to further the development of education for the health professions; to assist with improvement of the delivery of health services to all Americans; to conduct and support research in the medical and related sciences and to disseminate scientific information to protect the Nation against impure and unsafe foods, drugs, and cosmetics, and other potential hazards; and to provide for the prevention and control of communicable disease and other health functions.

In May and September of 1973, the Public Health Service underwent a reorganization to enhance the line and management authority of the Assistant Secretary for Health over the operating health agencies. The reorganization affected three existing health agencies, the National Institutes of Health (NIH), the Health Services and Mental Health Administration (HSMHA), and the Food and Drug Administration (FDA), and expanded them to six agencies. The major changes occurred within HSMHA. Currently, the Public Health Service consists of:

The Food and Drug Administration which remains unchanged.

The National Institutes of Health also remain unchanged except for the transfer of the Bureau of Health Manpower Education.

The Health Services Administration incorporates health service grant and direct delivery programs.

The Health Resources Administration contains health services data gathering and surveillance activities, health service research programs, health planning, and the former Bureau of Health Manpower Education transferred from NIH.

The Center for Disease Control remains headquartered in Atlanta, Georgia, and assumes responsibility for the National Institute for Occupational Safety and Health, and environmental health control programs.

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Alcohol, Drug Abuse and Mental Health Administration assumes responsibilities for alcohol, drug abuse and mental health as three institutes. This was a reorganization of those activities from the Health Services and Mental Health Administration.

A. Health Services Administration

The Health Services Administration (HSA) through its Bureaus (Community Health Service, Indian Health Service, Medical Services, and Quality Assurance), serves as a national focus for efforts to improve the organization and delivery of health services in the context of the major health care financing programs. To this end, HSA: (1) facilitates the development of locally-based programs of health services delivery: (2) initiates activities which provide alternate methods of health service delivery and health maintenance; (3) enhances the capacity of existing health service programs for full participation in the major public health financing systems—Medicare and medicaid; (4) administers programs providing specific services to specific populations, including migrant care, family planning, and maternal and child health care; (5) directs programs, including the National Health Service Corps, which assure accessibility to health care in underserved areas; and (6) improves quality and contains costs of services provided in grant-initiated health service delivery programs.

Formula grants to States

Comprehensive public health service formula grants supported under section 314(d) of the Public Health Service Act are available to State health and mental health authorities to assist in establishing and maintaining adequate public health services, including training State and local health personnel. The States are free to use these funds in areas of special local need with the proviso that 15 percent of a State's allotment must be allocated to the State mental health authority, and the State must provide services for the prevention and treatment of drug and alcohol abuse commensurate with the extent of the problem.

The law provides that funds be allotted to States on the basis of the State's population and financial need, and with the further provision that no State's allocation be less for any year than the total amount allotted for formula grants for the fiscal year ending June 30, 1967.

Among the activities that provide health services to both the general population of the States and to high risk groups within the States are communicable disease control, enviromental health programs, laboratory services, vital statistics, nursing services, and a variety of community mental health services. Some States have used the flexibility of formula grant funds to support new approaches to the delivery of health programs; others have expanded into new areas of service such as family planning, and dental and medical care clinics. While total program obligations for the formula health grant program increased slightly between fiscal 1970 and 1972, from $74 to $86 million, grants obligated to rural areas nearly doubled from $10 million in 1970 to $18.5 million in 1972. The proportion of obligations going to nonmetropolitan areas appears to have increased seven percent during that time, bringing the rural portion of total obligations for this program to 22 percent.

For further information on this program see OMB, *Catalog of Federal Domestic Assistance*, June 1974.

13.210 Comprehensive Public Health Services Formula Grants

Maternal and child health

The maternal and child health care program was established under title V of the Social Security Act of 1935. The provisions of the legislation enable States to extend and improve services for: (1) reducing infant mortality and promoting health programs for mothers and children, (2) locating crippled children and providing them with medical, surgical, and corrective care including hospital services, and (3) special projects of regional and national significance.

The legislation establishing maternal and child health and crippled children's services requires that special emphasis be given to rural areas and areas suffering from severe economic distress. This mandate is achieved through grants distributed by a formula which ranks States in reverse order of their per capita income, and for maternal and child health, counts each rural live birth twice for each urban birth, and for crippled children, counts child population under 21 twice in rural areas.

Programs providing dental and other health care services for children and youth are directed toward comprehensive care for children from low-income families. Maternity and infant care and newborn projects help reduce the incidence of mental retardation and other handicapping conditions associated with childbearing and help reduce infant and maternal mortality by providing necessary services to low-income mothers and infants. A 25-percent match is required for these programs.

Grants are available to State health agencies which may provide care directly or provide services through grants or contracts to local health agencies, public or nonprofit private agencies, organizations, or institutions. The programs require State plans and financial participation noted previously. Examples of services which States may provide under these programs are: prenatal and perinatal clinics, public health nurses, pediatric clinics, dental health clinics, special services for crippled children, speech and hearing services, child abuse identification, and nutritional services.

Population census figures demonstrate the need for adequate maternal health care in rural areas. Among white women in nonmetropolitan areas with incomes below poverty levels, the number of children under age 3 per 100 women in 1971 was 35 percent higher than for the Nation as a whole. The average for poor nonwhite women in nonmetropolitan areas was 60 percent greater. Service projects aim to respond to the lack of medical personnel and facilities and to the problems of transportation and information dissemination to help to relieve this situation.

While rural figures are not available for fiscal 1972, it is estimated that between 25 and 40 percent of the $60 million total for maternal and child health services was obligated to nonmetropolital areas. This figure corresponds to the 40 percent share of the $50 million total obligation that rural areas received in 1970. Approximately 44 percent of the $65 million total 1972 obligation for crippled children's services went to rural areas.

Although no data breakdowns are available, 8 of 62 children and youth projects out of a total fiscal year 1972 obligation of $47 million were located in rural areas; 5 of 18 dental projects out of a total of $1.2 million; and 16 out of 61 maternal and infant care projects out of a total of $43.3 million obligation were located in nonmetropolitan areas. The small proportion of projects can be attributed to the urban emphasis added to these projects by amendments to the legislation in the mid-sixties.

Public and nonprofit institutions are eligible for training grants in the maternal and child health care fields. Most training is conducted at university medical centers and teaching hospitals and has no specific rural problem orientation. One program in nurse-midwifery is, however, preparing nurse-midwives to give care particularly in rural areas through the entire perinatal period. Fifteen million dollars was obligated for this training in fiscal year 1972.

For further information on the programs discussed in the above summary, see OMB, *Catalog of Federal Domestic Assistance*, June, 1974.

13.211	**Crippled Children's Services**[1]
13.212	**Dental Health of Children**
13.218	**Health Care of Children and Youth**
13.230	**Intensive Infant Care Projects**
13.231	**Maternal and Child Health Research**
13.232	**Maternal and Child Health Services**[1]
13.233	**Maternal and Child Health Training**
13.234	**Maternity and Infant Care Projects**

Family planning

The mission of DHEW's family planning program is to enable people to have a free choice regarding the number and spacing of one's children. This is accomplished by providing information concerning the factors which influence the number and spacing of children as well as family planning and medical assistance services to people who both desire and need these services.

A particular goal of the program is for low-income women and families, many of whom live in rural areas, to have access to family planning information and, if they choose, family planning services. Low-income women and families continue to demand and need medical and social services to achieve family size and spacing expectations and to improve the health and well being of themselves and their families. Women using family planning services as part of organized programs are provided with a high level of preventive health care including pelvic and breast examinations, pap smears, and other laboratory tests.

Family planning services are provided through several legislative authorities. The Family Planning Services and Population Research Act of 1970 was enacted to assist in making comprehensive voluntary family planning services readily available to all persons desiring them, but with special attention to low-income people. Grants for this program are made available through direct project grants with a 25 percent matching requirement.

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[1] Special emphasis in rural areas and in areas suffering from economic distress.

The Social Security Act provides funding through States for family planning services in conjunction with maternal and child health care projects, and requires States to offer and provide family planning services to families and children receiving aid for dependent children payments and those enrolled in medicaid, providing reimbursement funding to the States for this purpose.

Rural areas received $18.4 million, or 22 percent, of the $83 million obligated for family planning services in fiscal year 1972. The Bureau of Community Health Service has indicated that emphasis has been gradually shifting from urban to rural areas in the last several years. In 1973, family planning services were available in 2,625 counties, both rural and urban. The 449 counties in which services were not available are very sparsely populated, containing less than 10 percent of the women estimated to need subsidized family planning services. There has been an effort to make services available in these rural counties. Currently, two-thirds of the family planning projects directly supported by the Department serve rural populations, although the projects may not necessarily be located in nonmetropolitan areas.

It has been estimated that nonmetropolitan areas will have 43 percent of the family planning patient load in 1975, based on the Census Bureau definition of rural. Nevertheless, these areas have the largest manpower gaps for family planning programs. Physicians are in the shortest supply. It appears that nurses will be in adequate supply if part-time positions can be created for currently inactive nurses. The availability of physicians in nonmetropolitan areas may present a barrier to provision of services in counties with low population density and no reported family planning services. On the other hand, it may be possible to meet this need through the training and utilization of family planning nurse-practitioners or other physician equivalents who can provide medical services associated with family planning care under medical supervision.

In 1974, another effort, research for services delivery improvement, had persons living in nonmetropolitan areas among its target populations. Techniques were studied for serving people in rural areas by different modes of service delivery, as was the feasibility of consumer participation in migrant health care delivery.

For further information on the programs discussed in the above summary, see OMB, *Catalog of Federal Domestic Assistance*, June 1974.

13.217	Family Planning Projects
13.232	Maternal and Child Health Service
13.260	Family Planning Services-Training Grants
13.714	Medical Assistance Program
13.754	Public Assistance-Social Services

Community health centers

Community health centers provide ambulatory health care through a wide range of health care services which are designed to meet the specific needs of a target population. Two types of community health centers are located in rural areas—the family health center and the neighborhood health center.

Family health centers are intended to demonstrate that a prepaid group practice having a specifically enrolled population can be designed for, established in, and meet the needs of people living in areas of health service scarcity. Health service scarcity is defined as an area: (1) where it has been determined that there is a shortage of health related personnel and/or facilities, or (2) where, despite a sufficient number of personnel and facilities, they are either inaccessible or ineffectively utilized by reason of geographic, monetary, administrative, or cultural barriers. Centers must be located in geographically defined scarcity areas; to date, emphasis has been primarily on inner city urban areas and to a lesser extent, on rural and semi-rural areas.

Family Health Center projects must have the capacity and capability to deliver, or arrange for the delivery of, a basic minimum service benefit package which must be available to each enrollee in the family health center. The basic package includes: emergency services including ambulance services, physicians' services (except when provided by a psychiatrist) and services by a pediatric nurse associate or paraphysician, and medical and other services, e.g., outpatient diagnostic services, outpatient physical therapy. Hospital and other nonambulatory services are arranged for and coordinated by the family health center. Of 30 family health centers which are currently being funded, 17 serve rural areas, and 2 serve both a rural area and an urban area.

Neighborhood health centers integrate health and social services into a single organization, incorporating sound preventive health measures which are predicated on total family care and which are designed to insure continuity of care. Services provided by neighborhood health centers vary from center to center, depending on the needs of people in a specific area and resources available to provide certain services. Among the services provided are medical, laboratory, dental, pharmacy, home health, transportation, social, and community, and X-ray. Of a total of 127 neighborhood health centers funded in fiscal year 1974, 25 neighborhood health centers served rural areas, and 6 served both rural and urban. In addition to having professional staff, community health centers provide local residents the opportunity to be hired and trained in paraprofessional careers in the health field, e.g., nurse practitioners, family health workers for outreach services, and medical records aides.

A major effort is under way to help each community health center to increase its collection of third-party reimbursements and to develop a viable financial plan. Not only will these activities contribute to improved financial management, but also to prepare each project to effectively deal with a national health insurance plan when one is implemented.

Community health centers are funded under Section 314(e) of the Public Health Service Act, which has a dual purpose: (1) to provide services and related training to meet the health needs of limited geographic scope or of specialized regional or national significance; and (2) to develop and support for an initial period new programs of health services, including related training. Both of these objectives are applicable to rural citizens where aspects of rural living such as poverty, sparse community resources, and lack of public transportation create special health care problems. Grants may be made to public or nonprofit private agencies, institutions, or organizations.

Rural areas received only $19 million, or 13 percent of the total of $144 million obligated for this program in fiscal year 1972. In fiscal year 1970, the rural share was $4.5 million, or 7 percent, of a total obligation of $65 million. The increase from fiscal year 1970 to 1972 is the result of the gradual takeover of the OEO neighborhood health center program by HEW, beginning in 1971 and completed by the end of fiscal year 1974.

The small rural proportion of the total is a result of the community health center program focus on providing services in urban as opposed to rural areas. The reason for this emphasis is twofold: first, the higher proportion of persons who live in urban areas, and second, the need to gain experience in developing workable models for the delivery of health care in rural areas through the family health center program. Based on the findings of the family health center program, a BCHS rural health initiative is planned for fiscal year 1975. It will involve an integration of efforts of the community health center, National Health Service Corps, and migrant health programs in providing comprehensive services for all members of rural communities.

For further information on the program discussed in the above summary, see OMB, *Catalog of Federal Domestic Assistance*, June 1974.

13.224 Health Services Development-Project Grants
13.261 Family Health Centers

Health maintenance organizations

A health maintenance organization (HMO) is a legal entity which provides a prescribed range of health services to a defined, enrolled population for a fixed, uniform, prepaid premium. The premium is not related to the number of times during a fixed period an enrollee uses services included in the HMO. Therefore, it is in an HMO's interest to encourage its enrollees to seek preventive care and early treatment of disease in order to decrease the need for hospitalization which is the most expensive aspect of health care. Studies have shown that HMO enrollees receive better care at less cost than persons in traditional medical care delivery systems.

Even though prototype HMO's have been in operation for over 40 years, only recently has the HMO been considered a viable alternative to traditional medical practice with private physicians and fee-for-service financing. In 1971, the President's health message to Congress marked the beginning of Federal encouragement to the HMO movement.

In December 1973, the Health Maintenance Organization Act was enacted, authorizing a 5-year program of support for the development of new HMO's and the expansion of existing ones. The act provides $375 million during this period in the form of grants, contracts, loans, and loan guarantees for feasibility surveys, planning, initial development, and initial operating deficits. An important feature of the act is the "dual choice" section. This provision requires that all employers with more than 25 employees offer the option of services through a qualified HMO if there is one in the area where the employees reside.

Another provision for increasing HMO development is the section on restrictive State laws which provides for the override of specific State laws which may block HMO development. The items for supersession are spelled out in the act and apply on a case-by-case basis.

The HMO legislation is based on the concept that HMO's may be one of the more effective means of dealing with specific problems in health care today. One major problem is the health care of rural residents, many of whom have no access to health care. Another is the spiraling cost of medical care, especially the double burden of loss of income and cost of care associated with catastrophic illness and chronic disease. Both of these situations are more likely to occur in populations which either do not or cannot see a doctor for routine preventive care. The HMO is looked to as a partial solution to some of these problems.

To encourage the development of HMO's in rural areas, the Health Maintenance Organization Act requires that 20 percent of the funds available for grants, contracts, loans, and loan guarantees in any fiscal year be set aside for projects in rural areas. The act defines a "nonmetropolitan area" as one in which no part is within a standard metropolitan statistical area, as defined by the Office of Management and Budget, and there is no city with 50,000 or more inhabitants. Two-thirds of an HMO's membership must be drawn from a nonmetropolitan area if the HMO is to be eligible for assistance as a rural HMO.

Two rural target populations, migrants and Indians, are specifically affected by the HMO Act. DHEW has authority to arrange for the provision of health services to migrant and seasonal farmworkers and their families through HMO's. In addition, with their consent, health care may be provided to Indians by private or other non-Federal health agencies or organizations through contract on a fee-for-service, prepayment, or other basis.

There are currently seven out of 39 operational HMO's serving rural populations. They are located in Farmington and Rockport, Maine; Nashua, N.H.; Danville, Pa.; Lincoln, Ill.; Grand Junction, Colo.; and Virginia, Minn. Funding for these projects currently totals $803,000.

For further information on the program discussed in the above summary, see OMB, *Catalog of Federal Domestic Assistance*, June 1974.

13.256 Health Maintenance Organization Service

Emergency health and medical services

It was originally envisioned that the emergency health program would provide citizens accessibility to medical care and equipment during times of natural or nuclear disasters and accidents or sudden illness. The program developed, planned, and administered programs covering all aspects of emergency health and medical services and resources applicable to contingencies ranging from natural disasters to thermonuclear attack.

The major activities through which the program assisted States and communities to prepare for major disasters were: (1) acquisition and strategic placement of essential health supplies and equipment for emergency use; (2) technical guidance in initiating and updating

State and community health preparedness plans; (3) training programs to implement community hospital in-service training courses and civilian mass casualty training courses; and (4) medical self-help training for individuals to care for themselves when professional health services are not available.

In 1971, under the leadership of the National Security Council, HEW participated in a study to determine alternative methods for carrying out Federal civil defense responsibilities. The study concluded that the most efficient method of maintaining a medical stockpile for possible nuclear attack was to maintain a dual-use stockpile also available to meet natural disasters; that a resource already existed in the Army field hospital system; that the HEW Emergency Health Service has contributed to a limited number of Presidentially declared civil disasters; and that any attempt to bring the Emergency Health Service stockpile up to current usefulness and to maintain it would be costly and duplicative. It was determined, therefore, that the Emergency Health Service program would be phased out during fiscal year 1974, and resources for emergency preparedness would be obtained from other sources. With regard to community preparedness and training, it was determined that those activities are properly State responsibilities with technical assistance to be provided by HEW through the regular staff in the Department's 10 regional offices.

In 1972, the last year of emphasis on disaster preparedness, $27,500 was obligated for the total program. Approximately $7,000, or 25 percent, was earmarked for nonmetropolitan areas.

The Public Health Service Act was amended by the Emergency Medical Services Act of 1973 (Public Law 93–154, November 16, 1973) to provide assistance and encouragement for the development of comprehensive area emergency medical services systems. The act authorizes the Department to make grants to and enter into contracts with eligible entities for: (1) feasibility studies and planning, (2) establishment and initial operation, (3) expansion and improvement, (4) research, and (5) training in emergency medical services. It is recognized in the Act that special problems exist in rural communities, and provision is made for emphasis and support to enable such communities to qualify for awards. Not less than 20 percent of the funds appropriated each year for feasibility studies, planning, establishment and initial operation, and expansion and improvement of emergency medical services systems shall be available only for such activities in rural areas.

Appropriations for the new emergency medical program were authorized in the latter part of fiscal year 1974, and $17 million was obligated for this program. The Emergency Medical Service estimates that nearly one-half of grants awarded in fiscal year 1974 were for services in rural areas.

For further information on the programs discussed in the above summary, see OMB, *Catalog of Federal Domestic Assistance*, June 1974.

13.284	**Emergency Medical Services**
13.285	**Emergency Medical Services Systems Research**

National Health Service Corps

The National Health Service Corps (NHSC) was created by the Emergency Health Personnel Act of 1970 and began operations in 1972. The Corps was established to assist communities having critical shortages of health manpower. The selection of communities for such manpower assistance is based on program criteria including doctor-to-patient ratio, health indicators, accessibility of health services, and willingness of the community to assume an active role in developing and managing a health practice with assistance from the NHSC.

The Corps represents a mechanism for placing health professionals in areas with critical health manpower shortages. In many cases, residents of these areas have not had other than distant emergency care available for long periods of time. NHSC also assists to develop the capability to independently attract and retain health professionals.

Of the 423 sites approved for Corps assignees, 392 have been classified as rural. Of the 357 NHSC assignees at this time, 245 are doctors, 51 are dentists, 51 are nurses or physician extender personnel, and 10 are other assignees.

Personnel are assigned without regard to an area's ability to pay. Average assignments are for a 2-year period. Approval for area designation is based upon recommendation of the appropriate State health planning agency and local and State professional societies.

Assignments are related to the ability of NHSC to match a community with the health professional from the recruitment and matching pool who has the highest probability of remaining in the community. At the present time, due to the emphasis on retaining personnel in these areas, health professionals are not forced to serve in communities other than those of their choice. Because of the broad number of choices available, in most cases a candidate for assignment can find a community which meets his specific professional and personal needs, so there is a high probability he will remain in that community.

Current information indicates that Corps assignments are bringing critically needed health services to a wide range of people. Among these are populations with significant numbers of the elderly, blacks, Spanish speaking people, migrant farmworkers, Indians, and residents of rural areas of Appalachia.

Numerous Corps assignments now provide readily accessible care to populations that formerly had to travel great distances for care—some as far as 70 miles. In other areas, existing health professionals were often both impossibly overworked and/or over 65. Several Corps assignments have been able to reduce patient loads of physicians who felt compelled to practice even though well beyond the usual retirement age.

For further information on the program discussed in the above summary, see OMB, *Catalog of Federal Domestic Assistance*, June 1974.

13.258 National Health Service Corps

Indian Health Service

The Indian Health Service is designed to meet three major objectives:

(1) To deliver high quality comprehensive health services which are amenable to local direction and manning by Indian

people and Alaska Natives in accordance with their stated wishes and abilities.

(2) To acquaint Indian people and Alaska Natives with available health programs for which they, as American citizens, are eligible; to encourage their participation in such programs: and to alert health program administrators to Indian and Alaska Natives' needs, and ways in which such needs can be met.

(3) To be responsive to the desires of Indian people and Alaska Natives to engage in a process of self-determination by providing options for them to man, manage, and otherwise guide and participate in the planning, operation and evaluation of health services delivery systems funded by the Indian Health Service.

The mission of the Indian Health Service is to elevate the health of Indians and Alaska Natives to the highest possible level and to require the availability of a comprehensive health service delivery system to serve these people. Approximately 444,000 American Indians belonging to more than 250 tribes and 54,000 Alaska Natives are eligible to participate in the program. For the most part, recipients must live on or near reservations and in other remote and isolated areas in 25 States—the majority west of the Mississippi. Because Indian reservations and the Alaska Native population are predominently nonmetropolitan, it is not surprising that over 80 percent of the $155 million obligated by the Indian Health Service went to rural areas in 1972.

Through its delivery systems, the comprehensive health services program of the Indian Health Service provides a full range of curative, preventive, rehabilitative and environmental health services. The program is carried out in 88 strategically located service units, utilizing a facilities system of 51 hospitals—each with an outpatient care department, 86 health centers, and over 300 health stations and satellite clinics. In addition, contracts are maintained with approximately 500 private or community hospitals, approximately 20 State and local health departments, and some 1,000 physicians, dentists, and other health specialists to provide hospitalization and specialized diagnostic and therapeutic services. Where possible, clinic space is also leased from Indian tribal groups in lieu of constructing new Federal facilities.

Environmental health programs provide basic environmental health services, engineering and technical support in the development of sanitation facilities, coordination with other agencies, and training of the Indian people in sanitation practices and operation of projects directed at improving overall environmental conditions. A continuing program of consultation and services has also been made available to Indians and Alaska Natives to assist them in implementing comprehensive environmental health programs and to maintain healthful communities. Since passage in 1959 of Public Law 86–121, enabling the construction of sanitation facilities, running water and waste disposal systems have been provided for over 78,000 Indian and Alaska Native homes.

A significant trend in the Indian health program has been the increased acceptance by Indians and Alaska Natives of health care services, especially utilization of ambulatory services. Hospital admissions have more than doubled; outpatient visits have increased by almost five times; 98 percent of babies are now born in hospitals rather than homes; and dental services have more than quadrupled. Since the inception of the Indian Health Service in 1955, the infant death rate has declined 67 percent, the death rate from gastritis and related diseases has declined 81 percent, the tuberculosis death rate has decreased 85 percent, and the death rate from certain diseases of early infancy has declined 66 percent.

Substantial gains have been made, but much remains to be done before reaching the goal of elevating the health status of Indians and Alaska Natives to the highest possible level. Their problems are more diverse, more severe, and are further compounded by cultural, socio-economic and geographic environmental factors. Using almost any accepted health index the health of these people is still far below national standards, and their health needs significantly exceed those of the general population.

In 1972, the Indian and Alaska Native infant death rate was 1.1 times higher than the comparable U.S. rate for all races; the tuberculosis death rate was 4.9 times higher, and the diabetes rate 2.1 times higher. Rates for influenza and pneumonia, accidents, and cirrhosis were 1.8, 3.4, and 4.1 times higher, respectively. Except for heart disease, malignant neoplasms, vascular lesions—all of which are increasing—and certain diseases of early infancy, the age adjusted mortality rates are considerably higher for Indians and Alaska Natives than for the general U.S. population.

For further information on the programs discussed in the above summary, see OMB, *Catalog of Federal Domestic Assistance*, June 1974.

13.228	**Indian Health Services**
13.229	**Indian Sanitation Facilities**

Migrant health

The migrant health program is authorized to provide community health services and grants for improving the health of migratory agricultural workers. Grants may be used to cover the cost of: (1) developing and operating family health services; (2) clinics for domestic migratory and seasonal farmworkers and their families; and (3) special projects designed to improve health services for workers and their families. Grantees must assume part of the project costs determined on a case by case basis.

The objective of the migrant health program is to support the development and enhancement of high quality health care services in rural areas for those eligible so as to raise the status of health to that of the general population. This can be achieved through the provision of comprehensive health services, made accessible to people as they move to and work in different places, and by improving the environment to assure healthy and safe living and working conditions wherever workers are located.

Project grants are available to public and other nonprofit agencies and organizations for an initial period of approximately 5 years. These funds can be used to establish and operate family health service clinics, to provide preventive and curative health services, and to support other projects such as education, training, and sanitation services in order to upgrade general health conditions. In 1972, $18 million was obligated for such grants—an increase of $4 million from 1970. The rural share of the total was nearly the same for both years—approximately 45 percent.

In 1974, there were 94 migrant health projects totalling $23.8 million which provided 630,000 patient visits at a cost of $67 per person per year. Forty-two percent of the migrants worked in 44 high impact counties (those with more than 6,000 migrants and seasonal farmworkers), all of which were served by migrant projects. The remaining migrants lived in 857 low impact counties, 32 percent of which were served by migrant projects. Because of the larger number of migrants in the patient base, projects in high impact areas generally can be larger and more ambitious than those in low impact areas. It is economically feasible to develop more comprehensive and accessible services in such high impact areas. Migrants or former migrants are employed as paraprofessional staff members in 98 percent of the projects.

Environmental health represents one of the most critical needs faced by migrant health projects. Many activities of the projects are negated by the unsafe and unsanitary conditions of migrant camps as was evidenced by the typhoid fever epidemic in Homestead, Fla., in January 1973. As a result of this, an inspection program of a random sample of migrant labor camps was undertaken to assess the extent of sanitation and other health problems in those camps and to recommend corrective action. Among the findings were the following:

(1) In 22 percent of the randomly selected camps, no water sample had been taken in the first 5 months of 1973; all of these camps were occupied and the water was being used without any assurance that it was safe.

(2) Thirteen percent dumped sewage directly into open streams.
(3) Thirty-five percent provided no toilet paper.
(4) Forty-nine percent had no screen doors.
(5) Twenty-five percent had no refrigerators.

The general level of sanitary conditions observed supports the position that a much more vigorous program of camp inspection and enforcement of existing State regulations regarding migrant camps is needed. Another problem concerns collecting third-party reimbursements for migrant health services. It is impossible for most migrants to meet State residency requirements in order to become eligible for State and local health and welfare aid.

Perhaps the greatest problem of the migrant health program is the need for additional resources and manpower. Intensive efforts to examine the problems of both migrant workers and rural inhabitants in general are necessary since both groups encounter similar problems. One appropriate mechanism for meeting the needs of migrant and seasonal farmworkers is to develop more stable comprehensive health centers in high migrant-impact rural areas. These centers have the capacity to deliver services to all segments of the population in the geographical target area, as well as to expand and contract services in accordance with the movement of migrant families. Future goals of the migrant health program are to support improved camp sanitation, to improve the management capabilities of projects, to provide limited hospitalization for migrants, and to ensure health care for those migrants who are in the low-impact counties.

For further information on the program discussed in the above summary, see OMB, *Catalog of Federal Domestic Assistance*, June 1974.

13.246 Migrant Health Grants

B. Health Resources Administration

The role of the Health Resources Administration (HRA) is to identify and correct current and anticipated deficiencies and imbalances in the supply, distribution, and utilization of health care resources and services. HRA measures current health status and trends through the National Center for Health Statistics. It tests new and alternative means of meeting health care problems through health services research. It promotes targeted resource development designed to improve areas of imbalance and inefficiency through programs for health manpower, health facilities, and health resources planning.

Comprehensive Health Planning

The development of the comprehensive health planning (CHP) legislation, referred to as the Partnership for Health Act, grew largely out of the concern for the nationwide shortage of health manpower and facilities and the recognition that present resources were not being used to best advantage. Section 314(b) of the legislation authorizes areawide grants for the development of comprehensive regional, metropolitan, or other local areawide plans for coordination of existing and planned services. Area agencies ("B" agencies) focus on assessing the total health needs or problems and all the resources—services, manpower, and facilities—to meet these needs or alleviate these problems in a particular area. In addressing itself to the health problems of people in target areas, the agency attempts to determine the circumstances and actions that contribute to or interfere with physical and mental health and a healthful environment. Areawide agencies seek to determine both gaps and overlaps in existing health programs and recommend courses of action to achieve targeted goals.

In an effort to coordinate new health activities proposed for the area, the "B" agencies have responsibility for review and comment on applications for Federal funds from approximately 20 different health programs. This review is intended to help ensure that federally funded health projects are in accord with the goals and priorities established by a CHP agency and thus in accord with the community's needs. In addition, agreements have been established with most of the States to carry out capital expenditures reviews to assure that Federal funds are not used to support unnecessary construction.

The Federal share of areawide grants does not normally exceed 60 percent. Approximately 75 percent of the Nation's population is now covered by areawide comprehensive health planning (CHP) "B" agencies. The remainder of the population is located primarily in sparsely settled areas. State CHP agencies ("A" agencies) are responsible for the health planning needs of these areas.

In addition, State agencies coordinate and supervise the activities of areawide agencies focusing on the interrelationships of the health needs of State populations and the allocation of scarce resources between the various areas. "A" agencies are supported by nonmatching formula grants distributed on the basis of population and per capita income.

Since its inception in 1966, the comprehensive health planning program has increased steadily. By fiscal year 1972, the program had grown to an annual obligation of $28 million, of which approximately 22 percent went to rural areas. Included in the total are areawide grants, grants to States, and grants for training, studies, and demonstrations in comprehensive health planning. The latter program accounted for $4 million of the totals. Very little of the $4 million is estimated to have gone to rural areas since training and demonstration grants usually go to universities.

Regional medical programs

The initial purpose of the regional medical programs (RMP) was to insure increased quality and availability of health care for all Americans by regionalizing resources for the diagnosis and treatment of heart disease, cancer, stroke, kidney, and other related diseases. Created by Federal funds in 56 autonomous regions covering the entire country, each program constitutes a cooperative arrangement among representatives of the health establishment of each region and includes both providers and consumers.

RMP has supported better utilization of existing health manpower, encouraged and enabled regionalization of health facilities manpower and other resources, and identified or assisted in developing mechanisms for quality control. Financial and technical assistance has been provided largely through project grants. Only designated regional medical programs have been eligible for grant funds, although institutions may initiate projects by applying to the RMP and receiving the approval of the regional advisory groups. During this period, fiscal years 1971 to 1973, $166 million was obligated to RMP.

During these fiscal years, 5 to 10 percent of the funds were obligated to rural areas. The small percentage is not surprising since virtually all the 56 regional medical programs are headquartered in metropolitan areas. All areas of the country, however, are covered by these programs.

For further information on the programs discussed in the above summaries, see OMB, *Catalog of Federal Domestic Assistance*, June 1974.

13.206 Comprehensive Health Planning—Areawide Grants
13.207 Comprehensive Health Planning—Grants to States

Health manpower

Activities focusing on health manpower development, distribution, and utilization are carried out primarily through grants and contracts with the Nation's health professions schools. In a limited number of instances, related educational entities are recipients of financial support. The Federal role in fiscal years 1972 and 1973 was directed toward a number of major needs and objectives. These can be summarized as follows: (1) maintaining expansion in the enrollment capacity and output levels of health professions education institutions in order to meet projected supply requirements, (2) facilitating and encouraging a more satisfactory geographic and specialty distribution of senior-level health professionals in order to promote better access to needed health care for all, (3) promoting equal access to health careers, particularly for traditionally underrepresented groups such as the disadvantaged, minorities, and women, (4) increasing the efficiency and productivity of health manpower of all types and in various combinations in the delivery of health care, (5) improving work force quality by increasing the general levels of knowledge and skill of existing health manpower, and (6) insuring improvement in the quality, relevance, and efficiency of the health manpower education process.

A total of almost $15 million of fiscal year 1973 funds was used to continue Federal support of 11 area health education center (AHEC) projects across the country. Support was provided to selected medical schools or university health sciences centers to continue a federally sponsored initiative in the decentralization of clinical experiences for both undergraduate and graduate medical and dental students and selected related health manpower. The educational experiences were purposely removed from the main campuses to underserved areas with the hope that because of the changes in training locations, an increased number of students would practice in these areas. However, it is too early to determine the success of the program in influencing the graduates in their selection of areas in which to practice.

Scholarship programs for both health professions and nursing in fiscal years 1972–73, were directly aimed at providing better access to health career training for economically disadvantaged students, particularly minority group representatives. The hope was that most recipients of this Federal support who were from nonmetropolitan areas would return to rural America to practice. To this extent, scholarship support had direct relevance for rural revitalization.

The loan-forgiveness provisions of the health professions and nursing student loan program had a direct bearing on the rural development goal. These provisions provided for payment by the Federal Government of almost the entire loan to any health professional or nursing graduate who agreed to practice for a period in shortage areas—most of which are nonmetropolitan.

Finally, the Comprehensive Health Manpower Training Act and nursing statutes contain authority to provide grants and contracts for special projects. In fiscal year 1972–73, these authorities provided a basis for limited, selected Federal support of medicaid and nursing schools providing increased health manpower for rural practice or for other shortage areas. For example, approximately 45 projects, which had as their primary or secondary purposes the provision of this increased health manpower, were funded in fiscal year 1973 under the Comprehensive Health Manpower Training Act—for a total of approximately $3 million. Four new grants were awarded in the nursing area in fiscal year 1973. Two of these were to establish professional nursing education programs on Indian reservations.

Other programs in the Bureau of Health Resource Development's fiscal year 1972–73 programmatic portfolio had a potential but indirect relevance for rural revitalization. The major ones included: (1) health professions and nursing capitation programs, (2) health professions and nursing teaching facilities construction support, (3) allied health and public health support programs, and (4) dental health and dental manpower support programs. While accurate data is not available on the various health manpower programs administered by the Bureau of Health Resource Development, one should note that the majority of the health profession schools are located in metropolitan areas.

For further information on the programs discussed in the above summary, see OMB, *Catalog of Federal Domestic Assistance*, June 1974.

13.305	**Allied Health Professions Special Projects**
13.319	**Dental Auxiliary Training Grants**
13.320	**Dental Health Continuing Education Training Grants**
13.339	**Health Professions Capitation**
13.342	**Health Professions Student Loans**
13.359	**Nursing Special Projects**
13.364	**Nursing Student Loans**
13.369	**Nursing Schools Construction Grants**
13.370	**Public Health Formula Grants**
13.378	**Health Professions Teaching Facilities—Loan Guarantees and Interest Subsidies**
13.379	**Family Medicine Residency Training Grants**
13.380	**Area Health Education Center Program**
13.381	**Health Professions Financial Distress Grants**
13.383	**Health Professions Special Projects**
13.384	**Health Professions Start-up Assistance**
13.389	**Nursing Schools Start-up Grants**

Health facilities construction

Hospital construction programs are designed to assist States in planning for and providing hospitals, public health centers, State health laboratories, outpatient facilities, emergency rooms, neighborhood health centers, long-term care facilities, rehabilitation centers, and other related health facilities through grants, loans and loan guarantees. Technical assistance is also offered to elevate the quality of design, construction, and operation of facilities.

The Hospital Survey and Construction Act (known as Hill-Burton) of 1946, has had a very significant impact on hospital construction, particularly in rural areas. The intentions of the act were twofold: (1) to assist States in surveying the need for hospitals and assisting in comprehensive planning for hospital construction, and (2) to provide assistance in financing needed construction. In 1964, the act was amended to establish a new program for the modernization or replacement of public and nonprofit hospitals and other health facilities. The 1964 Hill-Harris amendments also gave special consideration to facilities located in more densely populated areas. This marks a continuing shift in emphasis in the Hill-Burton program, which in its early days gave priority to construction of additional beds and facilities in rural areas.

Funding for the health facilities grant program is based on a formula, and the Federal matching share can be as much as two-thirds of allowable total costs. Up to 90 percent of total costs may be provided as an incentive to projects located in a poverty area to share services or otherwise cooperate with other facilities or reduce costs through free-standing outpatient facilities. Allocation of loans and loan guarantees to the States is based on a combination of the two grant allocation formulas.

State and local governments, hospital districts or authorities, and private nonprofit organizations are eligible for hospital construction funds. Private profit-making corporations are not eligible. All projects must receive approval from their local comprehensive health planning agency certifying need and appropriateness of the proposed new or modernized facility prior to applying for Hill-Burton funds and/or Federal Housing Administration mortgage insurance for hospitals. Each State must furnish HEW with a State facilities plan to be eligible for Hill-Burton funds.

In the past several years the hospital construction program has encouraged the trend toward construction of ambulatory care facilities instead of more costly hospital facilities. In fiscal year 1972 over half of Hill-Burton funds were for construction or modernization of public health centers, outpatient facilities, and rehabilitation facilities. This compares with 37 percent in 1971, 29 percent in 1970, and 24 percent in 1969.

Technical assistance activities have been focused on health facility planning based on the functions to be performed. Functional programing specifies in an orderly way the pattern of functional requirements of a hospital service as a prerequisite to the operational program and architectural design. In addition to developing publications for the functional programing of hospital departments, conferences, and consultations stress the importance of this concept as basic to the equipping and design of facilities.

Since 1963, health care facilities which do not adhere to the provisions of title VI of the Civil Rights Act, providing equal access for all persons regardless of race, religion, or place of national origin, are not eligible for new money from the Hill-Burton program. Nonadherence to title VI also prohibits health care facilities from participating in the medicare and medicaid programs.

Data on rural/urban proportions for the hospital construction program in 1972 is unavailable. Approximately $187 million was obligated for grants, loans, and loan guarantees that year as compared with the $234 million obligated in fiscal year 1970.

For further information on the programs discussed in the above summary, see OMB, *Catalog of Federal Domestic Assistance*, June, 1974.

13.220	**Health Facilities Construction—Grants**
13.223	**Health Facilities Construction—Technical Assistance**
13.253	**Health Facilities Construction—Loans and Loan Guarantees**

Health services research and development

The National Center for Health Service Research (NCHSR) supports studies to improve the availability, organization, distribution, utilization, quality, and financing of health services and health care facilities. Grants and contracts for research are offered to States, universities, political subdivisions and nonprofit institutions. Profit-making organizations are eligible only for contracts.

During the past 4 years, the Center has concentrated on the development of a better understanding of the needs, problems, and issues in rural health in terms of the geographical, political, technological, health resource, and population dispersement dimensions. Nevertheless, rural activities represent a small proportion of the Center's program.

The Center is funding a study to investigate the potential for increasing the availability of health care in rural areas by linking the administrative and medical service staffs of a major metropolitan hospital and dispersed satellite hospitals. Analytic studies of the issues in centralization versus decentralization which may yield insights into ways in which the fragmentation of care in large dispersed areas may be reduced are being funded by NCHSR.

The Center is also supporting experimental health services delivery systems (EHSDS) development in a number of communities that are primarily rural or include large rural areas. This program was initiated in June 1971, to establish health management corporations at the community level that, on the basis of broad community representation could address the problems of a local delivery system and effect improvements in access, cost, and quality of health care.

In one rural area the EHSDS is operating out of a community health center and acting as the major planning and development organization for most State and Federal health and welfare programs in a region of one particular State. EHSDS data system development has produced models for administration and data intake that are being adopted by many State programs.

In another area the EHSDS has worked closely and successfully with a university medical center to extend physician manpower into rural areas and is working with area hospitals to develop shared educational and laundry services. The EHSDS has also been instrumental in the development of an ambulant care center which is in initial stages of construction.

A family nurse practitioner program has been developed and demonstrated. The program trains nurses to serve in remote areas under telephone physician supervision. In addition, an emergency medical services system responsive to rural needs has been developed.

In the health manpower areas, the Center has focused its efforts on the training, licensing, and credentialing of two major types of physicians assistants, the Medex and Primex. The National Center for Health Services Research and the Bureau of Health Resources development have funded nine Medex programs for the training of assistants to the primary care physician for placement primarily in rural and urban ghetto areas. The Bureau is also currently supporting evaluation programs for three of these projects.

Reports as of January 1974, indicate that 250 of the 277 individuals who had graduated from these programs were delivering care in full time practice settings. An additional 207 were in training at that time. The majority of these graduates and trainees (63 percent) are working with physicians in towns less than 20,000 in size. Two of the Primex projects are family nurse practitioner training programs to prepare graduates to deliver primary care principally in free standing clinics in rural areas without a previous source of care.

Currently, NCHSR is focusing on the use of modern technology to improve the accessability of health care in rural areas. Slow scan TV for X-ray transmission and two-way interactive TV for dermatology and speech therapy are being used by physician extenders located in remote areas. NCHSR supports a project concerned with information flow in a dispersed health maintenance organization serving remote communities. Most recently, a contract has been awarded which will analyze the various manpower/technology mixes which can be used to deliver health care to the nation's rural areas.

Many of the NCHSR funded projects serve rural areas, and 6 percent of the $56 million obligated in 1972 went directly to nonmetropolitan sectors. This percentage results from research and training grants being given to universities which are generally located in urban areas.

For additional information on the programs discussed in the above summary, see OMB, *Catalog of Federal Domestic Assistance*, June, 1974.

13.225 Health Services Research and Development—Fellowships and Training.
13.226 Health Services Research and Development Grants and Contracts.

National health statistics

The National Center for Health Statistics (NCHS) is committed to provide a factual statistical basis for planning national programs designed to advance the health and wellbeing of the American people. This is in keeping with today's emphasis on improving the total quality of life rather than merely postponing death—an emphasis which naturally regards good health as much more than the absence of disease and infirmity.

Therefore, the Center provides national leadership in collecting, analyzing, and disseminating essential statistical data which should underpin the development of sound national health policies and programs. The health statistics training and technical assistance program provides three basic services: (1) collection, analysis, and dissemination of national and vital human statistics; (2) technical assistance and short-term training for State and local vital and human statistics personnel; and (3) advisory and counseling services for the promotion of State and local vital and human statistics training activities. Training and technical assistance activities are limited to government agencies, health and health-related institutions, and individuals having a legitimate interest in public health statistics.

NCHS is currently initiating support for the cooperative health statistics system. This system will provide for the production of comparable and uniform data for national, State and local levels of planning, management, and evaluation of health programs by providing the mechanism at the Federal level to promote and guide the development and operation of the system. Technical assistance and partial funding will be provided to enable States and localities to establish the appropriate systems which will produce the needed health data and which will become the members of the cooperative system. Only salary and expense (administrative) data is available on NCHS obligations. The majority of these monies go to metropolitan areas.

For further information on the above summary, see OMB, *Catalog of Federal Domestic Assistance*, June, 1974.

13.227 Health Statistic Training and Technical Assistance

C. ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

The Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) began operation in September 1973, and subsequently received authority in the statute by Public Law 93–282 in May 1974. The agency's three institutes previously existed in other areas of DHEW. ADAMHA as a public health service agency assumes the leadership of Federal programs designed to prevent, control, and treat alcohol abuse, alcoholism, drug abuse, and mental and emotional illnesses. The agency's mission is accomplished primarily through grants and contracts for research and investigation, training projects, and delivery of treatment services to people through community-based centers and programs.

Mental health

The National Institute of Mental Health (NIMH) plans, directs, and coordinates the development of knowledge, manpower, and services to promote and sustain mental health, prevent mental illness and treat and rehabilitate mentally ill persons. Underlying the extreme diversity of studies and projects is a clear unity of purpose: increasing scientific knowledge of the forces within and around the individual which affect or dictate his emotional and mental health, and the application of this knowledge in effective treatment and prevention services.

Research grants support the development of new knowledge and approaches to the causes, diagnosis, treatment, control, and prevention of mental diseases of man. Grantees develop and test new models and systems for mental health services delivery through organized systems and networks of services. Research directed specifically toward improving the mental health of rural America includes epidemiological and demographic studies to assess the extent of mental and emotional disorders and to determine what groups of people need help most; surveys of attitudes toward mental illness and mental health services; investigations of the effects of urbanization; and studies of rural delinquency and rural suicide rates.

As part of its program to improve rural mental health services, NIMH has supported a number of research demonstration projects intended to close the long existing gap between the State hospital and the rural community. In two States, provision of aftercare services to former patients from rural areas significantly reduced their rate of return to mental hospitals, and in a third, State hospital readmissions from four rural counties dropped 67 percent in 2 years. While there are no matching requirements, applicants for research grants must share at least 5 percent of the costs.

The greatest progress toward improving the mental health services of rural America has been made through the Institute's community mental health centers program. As of June 30, 1974, NIMH had funded 256 centers to serve one or more predominantly rural counties outside standard metropolitan statistical areas. These rural centers constituted 43 percent of all funded centers. Their service areas comprised 47 percent of all rural counties and about the same proportion of the people in such counties.

Although the program requires that community mental health centers serve a catchment area between 75,000 and 200,000 people, this requirement has been waived for about 13 percent of the centers. Of the approximately 70 centers receiving a waiver of the requirement, 29 serve areas of less than 75,000 people.

Rural centers, like urban, have an obligation to make mental health services readily available to everyone in their catchment areas. In fulfilling this obligation, they have to meet problems that are common to most centers but with special severity on those in rural areas. Among them are the problems of serving sparsely settled populations and of securing adequate manpower. Rural centers commonly cope with the problem of distance by establishing branch offices and outreach stations. They attract professionals by extolling both the attractiveness of their rural locations and the opportunity offered for new types of service. They train indigenous nonprofessionals for work that used to be restricted to personnel with professional degrees. Many count heavily on volunteers—in some cases even for therapy—and one uses several hundred "community representatives" to help or to get help for people in crisis.

Centers work to prevent mental and emotional disability by increasing the understanding of mental health principles and practices throughout their communities. Principal targets are teachers, doctors, nurses, clergymen, lawyers, and judges. Rural school systems in particular have been glad to contract for preventive mental health services they are unable to provide. As one measure of success, centers point to reductions in State hospital resident populations and also in admissions. In addition, one can also point to increasing caseloads.

The staffing grants of the community mental health center program increased considerably from 1970 to 1973—from $47 to $165 million. Construction obligations went from $12 million in 1970 to $13.6 million in 1973.

Project grants are awarded on a decreasing basis with poverty areas receiving up to ninety percent of the necessary funds. Nonpoverty areas receive seventy percent of the total cost. A poverty area is determined according to the percentage of people living in a catchment area who fall below the poverty limit as defined by the Social Security Administration.

Rural mental health services have shown greater improvement during the last decade than during all the years preceding. Nevertheless, room exists for further gains. Evidence of this is the fact that more than one-half of all rural counties and of rural Americans are still within areas not served by community mental health centers.

As the Institute has endeavored to increase the number of community mental health centers and to expand and improve their services, it also has endeavored to raise the capabilities of State mental hospitals, which are still the primary mental health resource in many rural regions. The Institute's hospital improvement program (HIP) grants have provided funds to State mental hospitals for projects which will improve the quality of care, treatment, and rehabilitation of patients. HIP has enabled many institutions to make a concerted effort to rehabilitate long-term chronic patients. Through activating therapy, behavior modification techniques, halfway houses, foster homes, community residences, and other methods, the majority of patients in such rehabilitation projects have been able to leave the hospital.

Through HIP a number of State hospitals have introduced the geographic unit system, perhaps the most effective innovation in hospital administration in recent years. This system divides buildings, corridors, or wings of hospital complexes into geographic sectors of the area served. This more easily enables a patient to have constant contact with visitors, social workers, volunteers or other personnel from his or her community. Other hospitals have used HIP funds to improve their services to older people, to establish children's units, to introduce programs for alcoholics, and to improve treatment of the "criminally insane." While there are no matching requirements for the HIP program an applicant must share some of the costs of the project.

Manpower development and training

To provide manpower for research on mental health problems, for delivering mental health services, and for training mental health workers, the Institute supports training programs that reach thousands of persons each year. Many of those programs are specifically for individuals already at work or intending to work in rural areas. Through grants for continuing their education, rural physicians are offered training in psychiatry; rural mental health specialists are helped to keep abreast of advances in their field; and persons in related fields—teachers, clergymen, social workers, nurses, and others—are trained to recognize those who need help and guide them to the services needed, or supply the services themselves.

Hospital staff development grants, a companion program of HIP, have enabled hospitals to give their staffs additional training to improve patient care. The Institute has also been largely responsible for the development of community college programs that prepare people, many of whom intend to work in the rural areas in which they live, for positions as mental health workers in mental health centers, hospitals, and various other social agencies. Priority goes to those which emphasize training disadvantaged persons and training for service to deprived populations. Numerous other training projects are directed at preparing Blacks, Indians, and Spanish-speaking Americans for service to members of their groups.

For further information on the programs discussed in the above summary, see OMB, *Catalog of Federal Domestic Assistance*, June 1974.

Research

13.242	Mental Health Research Grants
13.281	Mental Health Research Development Awards
13.282	Mental Health Research Manpower Fellowship Programs

Manpower development and training

13.238	Mental Health—Hospital Staff Development Grants
13.241	Mental Health Fellowships
13.244	Mental Health Training Grants

Service activities

13.237	Mental Health—Hospital Improvement Grants
13.240	Mental Health—Community Mental Health Centers
13.259	Mental Health—Children's Services

Alcohol abuse and alcoholism

There are three broad categories of programs administered by the National Institute on Alcohol Abuse and Alcoholism (NIAAA): research; manpower development and training; and alcohol community programs, which include all project grants and contracts for service, demonstrations and staffing.

Research

The extramural research grant program of NIAAA provides direct grants to universities and other public or non-profit institutions to develop new knowledge and approaches to the causes, diagnosis, treatment, control, and prevention of alcohol abuse and alcoholism. Because alcoholism is the result of a complex interaction of physiological, psychological, and sociological factors, research efforts deal with all aspects of this major health problem. Various aspects are the etiology of alcoholism, behavioral and biomedical effects of alcohol abuse, the interaction between alcoholism and other diseases, and the development of improved methods of treatment and rehabilitation.

Although the issues involved in the medical and non-medical aspects of alcoholism are of equal importance to urban and rural areas, and the research results are equally applicable, most research project grants are awarded to institutions in metropolitan areas. This is because the sophisticated nature of alcoholism research necessitates the utilization of larger, more complex medical and academic institutions where the more specialized facilities and personnel resources are located, and such institutions tend to be located in metropolitan areas.

Manpower development and training

The training program is to effect a change in attitude toward alcoholic people and problem drinkers through the development of qualified personnel in the area of prevention, treatment, and rehabilitation. This is being achieved by facilitating the inclusion of alcoholism training through grant support in such professional fields as medicine, social work, public health, psychiatry and psychology, as well as by the support of training programs of paraprofessionals and law workers in a new career program to provide services to combat alcohol abuse and alcoholism. This program also supports post-doctoral individual and institutional research fellowships. Counselors (usually individuals with less than professional training) who will function in both clinical and coordinating roles are also trained by the program's project grants.

A significant portion of the training programs are located in rural hospitals, colleges and Indian reservations. These training programs are of benefit in training both professional and lay persons in rural areas and in providing continuing education in effective methods of alcoholism intervention and rehabilitation to existing manpower in rural areas. In some instances grantees conduct satellite training programs for lay counselors in such rural settings as small Indian communities.

Community program assistance

Community Assistance Project Grants are given to a variety of projects that seek to prevent and control alcoholism. The projects integrate and involve a wide range of public and non-governmental agencies. Many of the projects are aimed at specific populations and/or specific types of problem drinkers.

Examples of projects aimed at special groups are occupational alcoholism grants, public inebriate grants, drinking driver grants, American Indian programs and poverty grants. Project grants are awarded on a decreasing matching basis.

Planning grants to local or nonprofit private agencies are authorized and used to cover the costs of the projects to plan and develop alcoholism services in a particular area. These initiation and development grants are to cover the cost of assessing local needs, designing alcoholism programs, obtaining local financial and professional support, and fostering community involvement in developing these services. However, no new initiation and development grants are being awarded.

Community Assistance Contracts are awarded to aid in the planning and development of alcoholism services at State and community levels. They are of short duration and are designed to meet specific needs emanating from States and communities. They contain limited staff and frequently are of national importance to the total alcoholism field. Contractors include a variety of types of agencies, e.g., management consultant firms, health research companies, etc. Performance sites may include health service agencies, local and state government planning units, and independent alcoholism facilities.

The Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 authorized formula grants to States for the development of prevention and comprehensive treatment and rehabilitation services throughout the individual States. The amount of monies available to the States is determined by a formula based on relative population, financial need, and need for more effective prevention, treatment, and rehabilitation programs to deal with alcohol abuse and alcoholism.

The Prevention Program is designed to assist communities to develop, implement and evaluate alcohol abuse and alcoholism prevention programs to meet the need of a heterogenous American society in which more than 100 million Americans are drinkers or users of alcoholic beverages. The prevention program grants and contracts are conducted in cooperation with schools, courts, penal institutions, other public agencies, and voluntary service organizations. The program provides counseling and educational activities on an individual or community basis for the prevention of alcohol abuse and alcoholism, and for the rehabilitation of alcohol abusers and alcoholic persons. One-third of the prevention programs are situated in rural communities. These programs are specifically designed to meet the needs found in nonmetropolitan areas. These needs include recreational opportunities, social opportunities, and enriched educational opportunities. Under the sponsorship of these prevention programs, schools have been opened in the evenings and on weekends so that parents and children may have an opportunity to work together in common areas.

For further information on the programs discussed in the above summary, see OMB, *Catalog of Federal Domestic Assistance*, June 1974.

Research

13.271 Alcohol Research Development Awards
13.273 Alcohol Research Programs

Manpower Developmental and Training

13.274 Alcohol Training Programs

Alcohol Community Programs

13.251 Alcohol Community Service Programs
13.252 Alcohol Demonstration Programs
13.257 Alcohol Formula Grants

Drug abuse

The National Institute on Drug Abuse (NIDA) administers four broad categories of drug abuse programs; community services, research, training, and information. Of these various programs, only community services impact directly on rural areas, though even this impact is not great. Of two-hundred fifty-two active treatment and rehabilitative—related grant projects in 1974, nineteen (eight percent) were located in rural areas. This fact is the result of the drug abuse problem being perceived as primarily urban, not rural. Furthermore, many of the treatment programs located in metropolitan centers also serve outlying rural areas.

Community services

Community programs seek to reach, treat, and rehabilitate narcotic addicts, drug abusers, and drug dependent persons through a wide range of community-based services by the provision of partial support of professional and technical personnel to staff drug abuse projects. Staffing grant funds may be used for temporary periods to pay a portion of the compensation of professional and technical personnel with some experience in prevention and treatment of narcotic addiction. Drug abuse service projects may provide detoxification services, institutional services, and/or community based aftercare services. Funds authorized for the Community Service program are on a matching basis. A higher percentage may be Federally funded if the area has been designated a poverty area.

The Narcotic Addict Rehabilitation Act program provides for civil commitment of narcotic addicts for examination and treatment as well as for rehabilitation and aftercare services. Eligible addicts may be committed under Titles I, II, and III of the Narcotic Addict Rehabilitation Act of 1966, for up to six months in a non-patient setting. After sufficient improvement, the addict may be placed in a rehabilitation program where he receives two and a half years of aftercare under the supervision of a social agency in his community under contract with the National Institute of Mental Health. An individual must be committed for examination to determine whether he is an addict and is likely to be rehabilitated through treatment before he is accepted into the program. This program has no matching or formula requirements.

Demonstration projects seek to cover the operational costs of programs for: (1) surveys and field trials to evaluate the adequacy of programs for the treatment of narcotic addiction and drug abuse for the purpose of determining ways and means of improving, extending, and expanding such programs; and (2) treatment and rehabilitation of narcotic addicts and drug abusers determined to be of special significance because they demonstrate new or relatively effective or efficient methods of delivery of services to such narcotic addicts and drug abusers.

Formula grants assist the States in the preparation of plans for planning, establishing, conducting, and coordinating projects for the development of more effective drug abuse prevention functions. Initial planning grant funds may be used only for expenses directly related to the preparation of the state plan. The grants are obligated by a formula based on population, per capita income, and number of chronic drug abusers.

The education program awards project grants and contracts to collect, prepare, and disseminate drug abuse information dealing with the use and abuse of drugs and the prevention of drug abuse. Education projects develop and evaluate drug abuse projects aimed at the general public, laymen, youth, teachers, and special high risk groups.

Research and training

The drug abuse research program seeks to develop new knowledge and approaches to the causes, diagnosis, treatment, control, and prevention of narcotic addiction and drug abuse. Drug abuse fellowships and career development awards provide training for research relating to the problems of narcotic addiction and drug abuse. The program also raises the level of competence and increases the number of individuals engaged in drug research via predoctoral, postdoctoral, and special levels of support.

Drug abuse training programs also support projects for treatment personnel to work with the drug addict or abuser. Projects may be for professionals, paraprofessionals, and exaddicts to work in drug treatment. Also, support is given to projects for the evaluation of teaching methods and for development of new training methods.

Information

The drug abuse information program provides for dissemination of information through a full-scale program of scientific communications and public information and education activities serving both the drug abuse professional community and the general public. No grant funds are provided. Assistance is given in response to inquiries from the scientific and general public, and to the printed and electronic media. Types of public information materials and activities include brochures, fliers, fact sheets, pamphlets and exhibits, news releases, news features, films, television and radio productions, articles for national magazines, and daily assistance to representatives of the public media. The National Clearinghouse for Drug Abuse Information serves as a central facility to coordinate information exchange in the anti-drug abuse field, with the foremost computerized repository of drug abuse and related research findings in the world.

For further information on the programs discussed in the above summary, see OMB, *Catalog of Federal Domestic Assistance*, June, 1974.

Community services

13.235 Drug Abuse Community Service Program
13.239 Narcotic Addict Rehabilitation Act Contracts
13.254 Drug Abuse Demonstration Projects
13.269 Drug Abuse Formula Grants
13.275 Drug Abuse Education Programs

Research and training

13.277 Drug Abuse Research Development Awards
13.278 Drug Abuse Research Manpower Fellowship Programs
13.279 Drug Abuse Research Programs
13.280 Drug Abuse Training Programs

Information

13.243 Alcohol, Drug Abuse, and Mental Health Administration Scientific Communications and Public Education

D. CENTER FOR DISEASE CONTROL (CDC)

The activities of the Center for Disease Control include: (1) maintaining active surveillance of diseases and distributing data related to preventable diseases and conditions; (2) initiating measures designed to prevent the importation or spread of communicable diseases from foreign countries into the United States; (3) providing technical and financial assistance to State and local health departments in the control and prevention of diseases, including environmentally induced human health problems; (4) assisting with epidemic aid to States and communities; (5) maintaining surveillance of the immunization status of the population; (6) developing new or improved standards and methods for the diagnosis, treatment, prevention or control of communicable and vector-borne diseases and other preventable conditions; (7) upgrading the performance of health workers engaged in prevention and control activities; (8) conducting a national program for improving the performance of clinical laboratories; (9) administering a nationwide program of information and education in the field of smoking and health; (10) and administering a national program to develop recommended occupational safety and health standards.

Venereal disease and immunization project grants are awarded to State health agencies and to some major city health departments. All State health departments provide venereal disease control and immunization services on a statewide basis, generally through health agencies and occasionally through private practitioners where public health agencies are not adequate. Current data indicate that children who live in non-SMSA areas are less well immunized against measles, polio, rubella, diphtheria, pertussis, and tetanus than children who live in central city SMSA and suburban areas. However, syphilis and gonorrhea rates remain lower in rural areas than in either small cities (50,000 to 200,000 population) or large cities (at least 200,000 population).

Approximately fifty-four percent of the 30,998 new cases of tuberculosis reported in the U.S. during 1973 were located in nonmetropolitan areas. Direct federal categorical grant support for out-patient tuberculosis care ceased in fiscal year 1971 and is now covered under formula grant authority. It is estimated that $10,000,000 per year of formula funds are spent for tuberculosis care with the percentage allocated to nonmetropolitan areas varying from State to State.

Technical assistance is provided by the federal government to State and local health departments in the development and implementation of tuberculosis control programs. Specific guidelines have been developed for tuberculosis control in low incidence or nonmetropolitan areas. In addition, the federal government is funding epidemiological impact activities to determine the feasibility of eradicating tuberculosis in nonmetropolitan areas.

The nutrition program, which had grown in the last few years, was eliminated in the past fiscal year. The target population of the nutrition program was all persons suffering from malnutrition, but especially children and pregnant and lactating women. Although resources were allocated on a priority-need basis, the more urbanized States generally received a greater portion of funds due to the "magnitude of the prevailing problem and the possession of greater resources." A CDC survey taken several years ago showed that malnutrition was a more severe problem in urban areas. There were, however, some special emphasis projects now being funded that deal with minority/rural nutrition improvement activities.

There were also some training courses for public health workers in nonmetropolitan areas in Fiscal Year 1972. They have been primarily geared toward disease control and prevention programing rather than emphasizing problems arising from local conditions.

Also within CDC is the National Institute for Occupational Safety and Health (NIOSH). NIOSH plans, directs, and coordinates the national program effort to develop and establish recommended occupational safety and health standards and to conduct research, training, and related activities to assure safe and healthful working conditions for every working man and woman. Under the provisions of the Federal Coal Mine Health and Safety Act of 1969, and the Occupational Safety and Health Act of 1970, research investigations, particularly those in which dose-effect relationships may be identified and quantified, thereby leading to the development of effective standards, represent one of the principal areas of responsibility of NIOSH.

In fulfilling its mission, the NIOSH employs many mechanisms including grants to eligible institutions and organizations to support research projects relating to innovative approaches to understanding the underlying characteristics of occupational safety and health problems and their solutions. Support is also available for demonstration projects designed for new or improved methodologies in dealing with occupational safety and health problems in all types of occupations, including agriculture and mining.

Since most of the grants are awarded to universities or research centers, very little money is spent in nonmetropolitan areas, though the eventual beneficiaries may be the rural populace.

For additional information on the programs discussed in the above summary, see OMB *Catalog of Federal Domestic Assistance*, June 1974.

13.262 Occupational Safety and Health—Research Grants
13.263 Occupational Safety and Health—Training Grants
13.268 Disease Control—Project Grants
13.283 Center for Disease Control—Investigation, Surveillance and Technical Assistance

E. FOOD AND DRUG ADMINISTRATION

The Food and Drug Administration (FDA) activities are directed at protecting the health of the nation against impure and unsafe foods, drugs, cosmetics, and other potential hazards. FDA directs three grant programs. Research grants are awarded to establish, expand, and improve research activities concerned with foods, shellfish sanitation, poison control, drug and cosmetic hazards, veterinary drugs, medical devices, biologics, and radiological health.

There are two different programs offering training grants, both at the graduate level. One training program aids colleges and universities in developing training opportunities for individuals interested in careers in research, teaching and administration in the food science and technology fields. A second manpower development program supports the training of radiological health specialists and technicians.

None of these programs has a significant immediate impact on nonmetropolitan areas since project activity most often takes place in research centers, colleges, or universities located in metropolitan areas.

For further information on the programs discussed in the above summary, see OMB, *Catalog of Federal Domestic Assistance*, June 1974.

13.103	Food and Drug Administration—Research Grants
13.104	Food Research Training Grants
13.106	Radiological Health Training Grants

F. NATIONAL INSTITUTES OF HEALTH

Research and training

Programs under the auspices of the National Institutes of Health cover wide areas of research and training. These include research and training in the areas of cancer, heart disease, arthritis and metabolic diseases, neurological disease and stroke, allergy and infectious diseases, child health and human development, studies of the eye, environmental health sciences, general medical sciences, general research and services, and the National Library of Medicine.

The overall objectives of NIH research programs are to conduct, assist and foster new and improved methods of research, investigations, experiments, and studies related to the cause, prevention, methods of diagnosis, and treatment of various diseases. Research projects are funded through both the grants and contract mechanisms. In many programs, current Federal legislation requires that the grantee contribute to the cost of each research project. Grantee eligibility is limited to universities, colleges, hospitals, public agencies, and non-profit research institutions which must submit applications for support by a named principal investigator. In special cases, a grantee may be an individual.

NIH training programs are intended to promote the improvement of medical and scientific research personnel through the development and enactment of research training programs. Financial assistance is rendered predominantly through project grants without matching requirements. Eligible applicants are usually public or nonprofit institutions capable of conducting a scientifically meritorious program of research training. An applicant may also be an individual who has received a doctoral degree or its equivalent, who has had postdoctoral experience in his line of endeavor, and who is a native born or naturalized citizen of the United States.

Given the requirement of cost sharing for grant funding and the small number of eligible institutions located in truly rural areas, it is not surprising that their receipts of NIH funds are in the neighborhood of five to ten percent for any one program's obligations. The satellite communications program of the Lister Hill National Center for Biomedical Communications in the National Library of Medicine is a program of importance to rural areas. This program is designed to take advantage of the progression of satellites which are in orbit to establish useful health services to be carried out in remote areas. For example, thirty remote communities in Alaska are tied through this network to a common resource for the provision of health services.

For further information on the programs discussed in the above summary, see OMB, *Catalog of Federal Domestic Assistance*, June 1974.

(A) Programs with indirect or marginal impact on nonmetropolitan areas:

(1) National Cancer Institute—Research and Training, OMB catalog numbers: 13.392, 13.394, 13.395, 13.396, 13.397, 13.398, 13.399

(2) National Heart Institute—Research and Training, OMB catalog numbers: 13.837, 13.838, 13.839

(3) National Institute of Dental Research—Research and Training, OMB catalog numbers: 13.840, 13.841, 13.842, 13.843, 13.844, 13. 845

(4) National Institute of Arthritis, Metabolism, and Digestive Diseases—Research and Training, OMB catalog numbers: 13.846, 13.847, 13.848, 13.849, 13.850

(5) National Institute of Neurological Diseases and Stroke—Research and Training, OMB catalog numbers: 13.851, 13.852, 13.853, 13.854

(6) National Institute of Allergy and Infectious Diseases—Research and Training, OMB catalog numbers: 13.855, 13.856, 13.587, 13.858

(7) National Eye Institute—Research and Training, OMB catalog numbers: 13.867, 13.868, 13.869, 13.870, 13.871

(8) Research Resources—Research and Training, OMB catalog numbers: 13.306, 13.333, 13.337, 13.371, 13.375, 13.877

(9) National Institute of General Medical Sciences—Research and Training, OMB catalog numbers: 13.859, 13.861, 13.862, 13.863

(B) Programs with potential impact on nonmetropolitan areas:

(1) National Institute of Child Health and Human Development—Research and Training, OMB catalog numbers:

13.864	**Population Research**
13.865	**Child Health Research**
13.866	**Aging Research**

(2) National Institute of Environmental Health Services—Research and Training, OMB catalog numbers:

13.872	**Environmental Health Sciences Centers**
13.873	**Environmental Mutagenesis and Reproductive Toxicology Research**
13.874	**Etiology of Environmental Diseases and Disorders Research**
13.875	**Environmental Pharmacology and Toxicology Research**
13.876	**Environmental Pathogenesis Research**

(3) National Library of Medicine, OMB catalog numbers:

13.348	**Medical Library Assistance—Library Resources**
13.349	**Biomedical Scientific Publications**
13.350	**Medical Library Assistance—Regional Medical Libraries**
13.351	**Medical Library Assistance—Research**
13.352	**Medical Library Assistance—Special Scientific Projects**
13.836	**Biomedical Communication Research**

CHAPTER III

EDUCATION DIVISION PROGRAM ANALYSES

In 1972 the education establishment underwent perhaps its most significant change since becoming part of the Department of Health, Education, and Welfare. The Education Amendments of 1972 (86 Stat. 327, 20 USC 1221e) created an Education Division under the supervision of the Assistant Secretary for Education. The Assistant Secretary reports directly to the Secretary and is responsible for coordination and general supervision of Departmental educational activities. The Division provides professional and financial assistance to strengthen State and local educational systems and programs. It is made up of the Office of the Assistant Secretary for Education, the Office of Education and the National Institute of Education.

Created originally in 1867 (14 Stat. 434; 20 USC 1), the Office of Education is mandated: (1) to collect statistics and facts showing the condition and progress of education in the United States, (2) to disseminate such information respecting the organization and management of schools and school systems and methods of teachings as shall aid the people of the United States in the establishment and maintenance of efficient school systems, and (3) to otherwise promote the cause of education.

The National Institute of Education has responsibility for providing leadership in the conduct and support of scientific inquiry into the educational process to provide more dependable knowledge concerning educational quality and to improve education, including career education. These goals are to be addressed through:

Helping to solve the problems of and achieve the objectives of American education including equal opportunity;

Advancing the practice of education as an art, science, and profession;

Strengthening the scientific and technological foundations of education, and

Building an effective educational research and development system.

Recently the Education Amendments of 1974 were signed into law with significant implications for rural areas. Specific regulations and guidelines are under development at the present time. Subject to the pattern of appropriations, there are many areas which can be highlighted for consideration in rural program development. These include continued support of the compensatory education concept, school library resources and instructional materials, provision for supplemental educational centers and services, bilingual education programs, additional support for education of the handicapped, a new funding

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set aside (15%) for innovative programs and teacher training in adult education, two new vocational education authorities for work with bilingual students, and extension of assistance for Indian Education.

Unique potential in the legislation (P.L. 93–380) includes a new National Reading Improvement Program and a Special Projects Act encompassing support for the gifted and talented, community schools, career education, consumers education, women's educational equity and education in the arts. Total authorization over a four-year period is twenty-five billion dollars for all purposes of the Education Amendments of 1974.

A. ELEMENTARY AND SECONDARY EDUCATION

Programs administered under the Elementary and Secondary Education Act (ESEA) of 1965 have one of the greatest concentrations of Office of Education (OE) funds. A large part of the Act reflects a formal policy recognition and commitment on the part of Congress and the Division of Education to children from low-income families who are educationally disadvantaged. The scope of the Act and the size of its authorizations make it potentially one of the most far-reaching programs in education for both metropolitan and nonmetropolitan areas.

Funding for most of the programs is by formula grants. The State/Federal funding relationship is organized so that a State's plan both informs the Federal Government about the State's priorities and also emphasizes comprehensive planning. Once the State Education Agency (SEA) receives its funds, it is legally required to review and approve local district plans and distribute ESEA money within the State.

Educationally deprived children (Title I)

Elementary and Secondary Education Act (ESEA) Title I funding is available to those Local Educational Agencies (LEAs) serving areas with concentrations of children from low-income families. Title I funds are intended to supplement existing support to expand and improve those educational programs which contribute to meeting the particular needs of educationally deprived children. While most funds are expended for special staff services and materials in reading and mathematics. States may also provide health, nutritional, counseling and special services for handicapped children in order to enhance educational opportunities for these children.

Title I also provides funding to local and State educational agencies to identify and meet the specific needs of migrant children.

Special projects in the areas of remedial instruction, health, nutrition and prevocational training may be funded on a formula basis in areas where concentrations of migrant children are found. Finally, State agencies responsible for providing free public education for neglected or delinquent children in State institutions may also qualify for Title I support.

Financial support under this title reaches approximately 14,000 local educational agencies and 500 State educational agencies. Funds are allocated at the Federal level by county and State agency for grants to LEAs. Applicant grantee projects are approved by their respective

State educational agency. In FY 1972, $632.4 million was allocated under Title I for nonmetropolitan areas.

A review of financial data from FY 1970, as compared with FY 1972, indicates that the total funding of the seven DHEW OE programs underwritten with Title I funds, *increased* by $223 million from $1.326 billion in FY 1970, to $1.549 billion in FY 1972. However, the percentage of total obligations to nonmetropolitan LEAs *decreased* over this period from forty-five to forty-one percent.

For further information on the programs discussed in the above summary, see OMB, *Catalog of Federal Domestic Assistance*, June 1974.

13.427	**Educationally Deprived Children—Handicapped**
13.428	**Educationally Deprived Children—Local Educational Agencies**
13.429	**Educationally Deprived Children—Migrants**
13.430	**Educationally Deprived Children—State Administration**
13.431	**Educationally Deprived Children in State Administered Institutions Serving Neglected or Delinquent Children**
13.511	**Educationally Deprived Children—Special Grants for Urban and Rural Schools**
13.512	**Educationally Deprived Children—Special Incentive Grants**

School library resources (Title II)

Support for school library resources, textbooks and other educational resources are included under ESEA, Title II. Funds are distributed to State departments of education by formula based on the total number of children enrolled in its public and private schools in proportion to the total enrollment of all States. Special consideration is given to children attending rural and Indian schools by reserving up to three percent of the total national allotment for the improvement of library resources in such schools.

Under a companion program, the Library Services and Construction Act (LSCA), Titles I and II, funds are made available to State library extension agencies for the construction and initial equipment of library facilities in areas without library service. There are also formula grants designed to serve those in localities which have inadequate or no library facilities.

Grants to nonmetropolitan areas funded under ESEA, Title II, increased in both total obligations and in percentage of total Title II obligations during the period FY 1970 through FY 1972. Obligations for nonmetropolitan areas increased from $4.1 million, or approximately ten percent of total, in FY 1970 to $10.2 million, or eleven percent of total Title II obligations in FY 1972.

For further information on the programs discussed in the above summary, see OMB, *Catalog of Federal Domestic Assistance*, June 1974.

13.406	**College Library Resources**
13.408	**Construction of Public Libraries**
13.464	**Library Services—Grants for Public Libraries**

Supplemental education center (Title III)

Programs under Title III include grants for supplementary educational centers and services, assistance in providing vitally needed educational services not available in sufficient quantity, assistance in the establishment of exemplary educational programs and assistance to States in maintaining programs of testing and counseling. Through both project and formula grants, State and local educational agencies are able to undertake projects at the preschool, elementary and secondary school levels which hold promise of making a substantial contribution to the solution of critical educational problems common to many or all States.

Title III funding is intended to supplement, not supplant, existing funds for the benefit of children in public and nonprofit private schools as well as preschool age children. Provision is also made for handicapped children by requiring that at least fifteen percent of funds for Title III programs be earmarked for the benefit of this special group.

During fiscal year 1972, obligations under the Supplementary Educational Centers and Services, Guidance, Counseling and Testing program totaled $121.7 million with $17.5 million for nonmetropolitan areas. There is insufficient data available to show obligations for rural areas funded under Title III authority.

For further information on the programs discussed in the above summaries, see OMB, *Catalog of Federal Domestic Assistance*, June 1974.

13.516	**Preschool, Elementary and Secondary Education—Special Programs and Projects**
13.519	**Supplementary Educational Centers and Services, Guidance, Counseling, and Testing**

State administration aids

Title V authorizes grants to State educational agencies to strengthen their leadership resources and to assist them in the establishment and improvement of experimental programs to identify and remedy educational needs of the State. Grants are made both on a matching and formula basis according to approved State plans which include such projects.

On a fifty percent matching basis, grants under Title V may be made to State educational agencies for the identification and evaluation of educational needs and issues, processing and analyzing educational data and the dissemination of information relating to the condition and progress of projects undertaken under this title. In addition, Title V funding may be used for discovering and testing new educational ideas such as video-taped lessons and audio-visual media. Up to five percent of total Title V funding may be used on experimental projects to develop innovative solutions to educational problems.

During the period fiscal year 1970 through fiscal year 1972, total program obligations under Title V increased from $29.7 million to $32.7 million. According to the enabling legislation, ninety-five percent of the obligations go to the State educational agencies for use within their respective States. The remaining five percent must be used by two or more States working jointly on common educational problems. While data is not available on the exact sums obligated specifically for the benefit of rural areas, it is safe to state that at least fifty percent is used for that purpose. This is because the funds flow directly to the States for use as they see fit according to their educational plans.

Large metropolitan school systems have staff to work on curriculum and transportation problems. As these are the types of problems the State educational agencies cope with, the results of the state's efforts benefit the rural schools which do not generally have the capability to deal effectively with those problems.

For further information on the programs discussed in the above summaries, see OMB, *Catalog of Federal Domestic Assistance*, June 1974.

13.485 **Strengthening State Departments of Education—Grants for Special Projects**
13.486 **Strengthening State Departments of Education—Grants to States**

Bilingual education (Title VII)

Title VII, E.S.E.A., was created in recognition of the special educational needs of the large numbers of children of limited English-speaking ability in the United States. Grants may be made to local educational agencies or institutions of higher education applying jointly with a local educational agency to develop and operate bilingual educational programs and services which meet the needs of children age three to eighteen years, who come from homes where the dominant language is not English.

While the bilingual program is directed primarily toward Spanish speaking children, certain local educational agencies across the nation have bilingual programs for children where French or American Indian dialects are the dominant language spoken at home. This title also provides assistance to the Alaska Native and other unique language groups. Local educational agencies which are receiving Title VII funds are eligible for additional funding to extend their bilingual teaching to the parents of the children served if the need exists for such a program. Title VII utilizes project grants to supplement, not supplant, existing programs at the local level. Obligation levels in fiscal year 1972 and 1973 were $35 million with an estimated $8.5 million for nonmetropolitan areas.

For further information on the programs discussed in the above summary, see OMB, *Catalog of Federal Domestic Assistance*, June 1974.

13.410 **Dropout Prevention**
13.519 **Supplementary Educational Centers and Services, Guidance, Counseling and Testing**

Dropout prevention (Title VIII)

The Dropout Prevention Program, funded under Title VIII of E.S.E.A., is designed to foster the development of exemplary educational programs which show promise of reducing the number of children who do not complete their education in elementary and secondary schools. Projects funded involve the use of innovative methods and materials to reduce the dropout rate. In recognition that children begin to drop out of school long before they reach the secondary level of education, affected school districts are encouraged to introduce basic changes in organization, teacher training and curriculum. Since the Dropout Prevention Program is designed to develop model programs which can be replicated in school systems across the nation, emphasis is placed on accountability for results in both educational accomplishments attributable to specific techniques and the cost effectiveness of instructional and management procedures involved.

Project grants under Title VIII are made to local educational agencies which distribute the funds to eligible school districts. In order to be eligible for funding, a school must have a high percentage of children from families with an annual income of $3,000 or less or a high percentage of children who fail to complete their secondary education.

Changes in dropout rates among school districts with continuing dropout prevention programs have been very gratifying. Over the period 1968 to 1972, the dropout rate has declined from approximately 8.7 to 4.5 percent. During the period FY 1970 to FY 1972, obligations for project grants under Title VIII increased from $5.6 million to $6.2 million.

For further information on the programs discussed in the above summaries, see OMB, *Catalog of Federal Domestic Assistance*, June 1974.

13.403	Bilingual Education
13.501	Vocational Education—Work Study
13.502	Vocational Education—Innovation
13.519	Supplementary Educational Centers and Services, Guidance, Counseling and Testing

B. Higher Education

Enrollment in institutions of post secondary education in the United States has increased each year since the early 1950's, rising from 2.1 million in 1951 to an estimated 9.3 million in 1972. There has been a concomitant increase in the number of faculty members, in the number of degrees conferred, and in expenditures for higher education.

Since tuition and fees cover less than half of classroom instructional costs, the need for additional sources of funds has grown with the increase in enrollment. State government subsidies, endowments, and gifts have not made up this "instructional deficit." Additional assistance may be available through the following Office of Education programs.

Program assistance

Several programs are available to assist colleges and states to improve or maintain the quality of post secondary education. A program for land-grant colleges distributes funds on a formula basis to each State, which in turn makes awards directly to its land-grant college(s). About one-fourth of the money is proportioned among the States on the basis of population; the remainder is distributed equally among them. Colleges can use funds to support instruction in the mechanical arts, agriculture, home economics, English language, science, or for equipment and training for such instruction.

Cut-backs in the land-grant college program reduced FY 1972 obligations to $12.5 million, a loss of $7 million from 1970. Since the legislative authority of the program requires primary assistance on a formula basis which grants the same amount of money to each State regardless of population, metropolitan areas suffered most. Actual rural obligations remained stable at slightly over $3.2 million, although their share of the total was increased from sixteen percent in fiscal year 1970 to thirty percent in fiscal year 1972.

Another program, Strengthening Developing Institutions, assists colleges in bolstering their academic, administrative, and student service programs so that these institutions may participate adequately in the higher education community. By definition, a developing institution is, for financial or other reasons, struggling for survival and isolated from the main current of academic life.

Project grants are available for cooperative arrangements whereby developing institutions and other institutions or agencies share resources. National financing fellowships are given to outstanding graduate students and to junior faculty members to teach at developing institutions. Support is also available for professors retired from established colleges to teach and to conduct research in developing institutions. Projects usually include demonstration and innovation and are developed on the basis of specific needs of the applicant institution.

The Program expanded considerably between 1970 and 1972, from $30 million to $47.1 million. Rural areas received approximately forty-five percent both years. This high percentage reflects the fact that economically distressed and minority schools, which are the primary recipients, tend to be located in nonmetropolitan areas.

Two new higher education assistance programs have been implemented since 1972. The Fund for the Improvement of Post Secondary Education provides project grants and contracts to institutions and agencies which develop and demonstrate innovative approaches to higher education. Priority is accorded to activities which relate to learner-centered change, increased cost-effectiveness, increased diversity and needed structural change. Planning grants are awarded to State higher education agencies or commissions to conduct comprehensive planning through inventories and studies of all public and private post secondary resources in a State.

Construction

The financial squeeze also affects the ability of colleges and universities to finance capital outlays for new facilities for growing student bodies. Sound planning for long-range statewide needs is necessary if Federal funds for facilities are to be used effectively. Financial resources can then be made available to insure construction of the needed facilities.

Project grants are offered to State commissions for comprehensive planning to determine the construction needs of institutions of higher learning. Grants are also offered to these commissions for administering State plans required under Title I of the Higher Education Facilities Act. Grants which are allocated to the states on the basis of a formula cover full costs of facilities planning projects.

Prior to fiscal year 1974, there were a number of higher education construction grant and loan programs. Included were formula grants for construction, interest subsidization, grants for community colleges and public and private colleges and universities, grants for instructional equipment and a direct loan program. Beginning in fiscal year

1973, some of these were phased out, and no higher education construction funds were appropriated either for fiscal year 1974 or 1975.

The decline in funding for construction programs began in fiscal year 1972 when $81 million was obligated, a decline of $2.1 million from fiscal year 1970. The rural share of construction grants increased, however, from thirty-three percent in 1970 to thirty-seven percent in 1972.

Personnel development

In 1959–60, institutions of higher education employed 418,788 professional staff members. By 1969–70, the Office of Education estimated the number had almost doubled to 806,000. Several Federal programs offer fellowships and grants to increase the supply of well-prepared teachers, administrators, and educational specialists for both community colleges and four-year colleges and universities. Fellowships are offered through institutions of higher education, which have high quality graduate level programs.

These programs are in the process of being phased out, however, a reflection of the change in emphasis from encouraging graduate level work to supporting aid for undergraduate studies. Between FY 1970 and FY 1972 obligations for higher education personnel declined by almost half, from $58 million to $32 million, although the rural share remained constant at twenty-seven percent. Since FY 1973, NDEA doctoral-level fellowships have been primarily reserved for returning Vietnam veterans.

Student aid

Although students pay only a fraction of the total cost of their education, they have been paying more and more in actual dollar amounts in recent years. An Office of Education survey conducted in 1961–62 reported average tuition and fees of $218 for all public institutions of higher education and $906 for private colleges and universities. The 1973–74 estimate is $412 for public schools and $2,044 for private schools. Room and board have at least doubled during the same period.

Federal job, scholarship, and loan programs aid some students who cannot afford all or part of these rapidly escalating costs. Most of the programs are project grants to institutions which then provide financial assistance to the individual students.

Students financially unable to pursue higher education are aided by Supplemental Educational Opportunity Grants (SEOG), formerly the Educational Opportunity Grants (EOG) Program. Almost all eligible institutions that apply for the SEOG program are funded. An institution must provide recipients of SEOGs with additional financial aid in an amount at least equal to the SEOG award, and may not reduce its total expenditures for student aid. Although there was a five percent increase in total SEOG obligations, from $167.7 million to $177 million between fiscal years 1970 and 1972, rural areas had a slight decrease in their percentage of the total: thirty-six percent, or $63.6 million, in 1972 compared to thirty-nine percent, or $65.3 million in fiscal year 1970.

In 1972, a new Basic Educational Opportunity Grant program was created for undergraduate students beginning to pursue full-time undergraduate studies at eligible institutions. The objectives of the program are somewhat similar to the SEOG program, however, the amount of an individual grant is based on family income contribution schedules and the cost of tuition. In no case may the individual grant be less than $50 or more than $1400 per year and may not exceed half of the cost of attendance at the particular institution. Total obligations for fiscal year 1973 amounted to approximately $122 million; estimated obligations for fiscal year 1974 are $475 million with the program potentially expanding to $1.3 billion in fiscal year 1975.

The National Direct Student Loan Program (NDSL) has established loan funds at eligible institutions to enable needy graduate and undergraduate students to complete their education. Students may become eligible for partial cancellation of their loans through certain types of teaching or service in the Armed Forces in combat zones. Monies are distributed among institutions according to a formula whereby the institution must provide one dollar for each nine dollars of Federal monies. Institutions may apply for a loan to cover their share, if necessary.

During the interval between 1970 and 1972, the direct loan program increased fifty percent from $194 million to $286.5 million. The rural proportion of the total decreased slightly from 37.5 percent ($72.6 million) to 34 percent ($96.8 million). At the same time, non-metropolitan areas accounted for close to half of the $3.3 million student loan cancellations.

The Guaranteed Student Loan (GSL) program insures loans for educational expenses. Loans are available from nearly 20,000 lending institutions throughout the country. Loans may be used only to pay costs of obtaining postsecondary education. This program has also increased considerably from $104 million in 1970 to $165.7 million in 1972, a gain of sixty percent in a two-year period. Only fourteen percent, or $22.9 million of the obligations went to rural areas. A contributing factor to this low percentage is that most of the lenders with sufficient assets for student loans are located in metropolitan areas.

Closely allied to the guaranteed loan program is the Student Loan Insurance Fund. This revolving fund operates to reimburse lending institutions for student loans which are defaulted. A total of twenty-seven million dollars was obligated to cover defaulted loans in 1972. Ten percent, or $2.7 million, went to nonmetropolitan areas.

A separate student loan program is available to Cuban refugees. In FY 1972, nearly ninety-nine percent of the $3 million obligated for the program went to urban areas. This percentage is to be expected, since nearly all the eligible applicants both live in and attend colleges and universities in metropolitan areas.

To encourage part-time employment of students, particularly those from low-income families, the College Work-Study (CWS) program gives project grants to colleges and universities. Students who need earnings from employment to continue their education are employed by the college or an off-campus agency. The employer pays twenty percent of the student's salary; Federal grants pay the rest. Recent cutbacks in Federal allocations have raised the minimum criteria for student eligibility under this program.

A related program, cooperative education, provides students with alternate periods of full-time academic study with periods of full-time public or private employment. Money appropriated under this program may not be used for student's salaries, but may be used to pay for salaries and administrative expenses incurred in the planning, implementation, strengthening, or expansion of such programs.

A comparative analysis of obligations for fiscal year 1970 and 1972 is not available, since Congress changed the funding for the College Work-Study and Cooperative Education programs from a calendar year to fiscal year basis in 1972. During the eighteen-month funding period, nonmetropolitan institutions of higher education received thirty-seven percent of total obligations, a decline of five percent from 1970.

Upward mobility

Another set of programs aims to bring disadvantaged students into institutions of higher education and assist them in successful completion of their academic programs. Upward Bound awards funds to institutions to establish precollege preparatory programs designed for high school students from low-income families who lack adequate secondary school preparation. The program stresses in-depth counseling with parents and students and the development of academic skills. In the past, institutions in nonmetropolitan areas had found it difficult to meet the twenty percent requirement, but this was eliminated by the 1972 Education Act Amendments. The one-time limit on Federal expenditures per student has also been eliminated, although the average expenditure per pupil is still only $1,200 to $1,400.

Talent Search is directed toward young people from Grade 7 and up who are "of financial or cultural need with an exceptional potential" for postsecondary education. Project grants are awarded to institutions and agencies which offer counseling, advisory, and higher educational planning services. There are no matching requirements, but the applicant is encouraged to seek partial project support from non-Federal sources. The one-time maximum grant of $100,000 has been eliminated.

Special Services for Disadvantaged Students assists low-income and physically handicapped students on college campuses. Educational institutions receive project grants to pay for counseling, tutoring, and other instructional services. Insufficient appropriations have limited the potential impact of the program. Individual student grants or loans are usually too small to meet needs of disadvantaged students.

The $46.5 million spent for these three programs in fiscal year 1972 was an either percent increase over the total $43 million obligated in 1971. The rural proportion of the total is thirty-three percent—the same percentage as in fiscal year 1970.

A new program to provide coordinated intensive services to facilitate entry into postsecondary programs was inaugurated in fiscal year 1974. Educational Opportunity Centers located in areas with major concentrations of low-income persons provide information concerning financial and other assistance available for area residents who seek postsecondary education. These centers assist in preparing applications and other forms for admissions and financial assistance. Centers also provide tutoring and counseling for enrolled students and serve as pools to coordinate resources and staff efforts in recruiting and counseling for admissions to postsecondary institutions. Of the approximately $3 million obligated for these activities in fiscal year 1974, most of it probably went to urban areas, where the problems of low-income are considered more acute. Centers in metropolitan areas can also serve greater concentrations of people.

For further information on the programs discussed in the above summary, see OMB, *Catalog of Federal Domestic Assistance*, June 1974.

Program assistance

13.453	**Higher Education—Land-Grant Colleges and Universities**
13.454	**Higher Education—Strengthening Developing Institutions**
13.538	**Fund for the Improvement of Post Secondary Education**
13.550	**Post Secondary Education Statewide Comprehension Planning Grants**

Construction

13.455	**Higher Education Academic Facilities—State Administration**

Personnel development

13.407	**College Teacher Graduate Fellowships**
13.462	**Higher Education Personnel Fellowships**

Student aid

13.409	**Cuban Education—Student Loans**
13.418	**Supplemental Educational Opportunity Grants**
13.460	**Higher Education Act Insured Loans**
13.463	**Higher Education—Work Study**
13.469	**National Defense Education Act—Loans to Institutions**
13.470	**National Direct Student Loan Cancellations**
13.471	**National Direct Student Loans**
13.510	**Higher Education—Cooperative Education**
13.539	**Basic Educational Opportunity Grant Program**
13.540	**Higher Education—Cost for Veterans' Instruction**

Upward mobility

13.482	**Special Services for Disadvantaged Students in Institutions of Higher Education**
13.488	**Talent Search**
13.492	**Upward Bound**
13.543	**Educational Opportunity Centers**

C. ADULT AND VOCATIONAL EDUCATION

Pursuant to the Vocational Education Act of 1963, as amended, the Office of Education provides Federal grant assistance to states to maintain, extend, improve and develop programs of vocational education. Part-time employment for youths who need the earnings to continue vocational training may also be provided. The Office of Education has implemented an array of programs, each designed to reach a specific group. Together they comprise a comprehensive vocational training system to reach those in high school or those who have discontinued their formal education and are preparing to enter the labor market, those who have entered the labor market but need to upgrade their skills and those with special educational handicaps.

In the area of direct training, the Basic Grants to States and the Consumer and Homemaking Program provide formula grants to state boards for vocational education to assist in conducting vocational programs for persons of all ages and in all communities who desire and need training for career vocations. Emphasis is placed on programs located in economically depressed areas or areas with high rates of unemployment. In FY 1972, total obligations under these two programs totaled $409.4 million with $53.5 million, or thirteen percent, going to nonmetropolitan areas.

The Special Needs Program fills the educational needs of persons with academic, socio-economic or other social handicaps. It is not for mentally or physically handicapped persons, but is specifically designed to prepare those who are from poor or educationally deprived environments for productive and meaningful employment. Formula grant assistance is provided to state boards for vocational education and is based on plans approved by the Commissioner of Education through the Regional Director of Occupational and Adult Education. Total obligations in FY 1972 were $20 million with fifteen percent or $2.6 million going to nonmetropolitan areas.

The Vocational Education-Work Study Program assists economically disadvantaged full-time vocational education students, ages fifteen to twenty, to remain in school by providing part-time employment with public employers. On a formula grant basis, funds may be used for the development and administration of the program and for compensation of students employed by the local educational agency or other public agencies. Obligations during fiscal year 1973 were $10.5 million.

The Cooperative Education Program is an effort to provide more diversified vocational training by cooperating with other vocational education projects in order to expose students to varied aspects of their new skills. In addition, work-study projects may be funded under this program. No Federal funds are paid directly to the students for their work. Compensation due them for their period of on-the-job training is paid by the employer. Priority for funding cooperative work-study programs through local educational agencies must be given to areas that have high rates of school dropouts and youth unemployment. Federal funds made available to a state under this program must not be commingled with state or local funds. Obligations in fiscal year 1973 and fiscal year 1974 remained steady at $19.5 million. There is insufficient data to make a determination of the percentage of obligations for rural areas.

In the area of research and demonstration, two programs are operational. They are the Research Program and the Innovation Program. The former is to provide (1) research, training and pilot programs designed to meet special vocational needs of youths, and (2) disseminate information derived from these projects. On a formula and project grant basis, vocational research, personal training and pilot programs are designed to meet particularly the needs of youths who have academic, socio-economic and other handicaps. These programs enhance the development of new careers and occupations. FY 1973 obligations were $9 million.

The Innovation Program develops, establishes and operates occupational programs as models for vocational education projects. As with other vocational education programs, special emphasis is placed on youths who have academic, socio-economic or other handicaps. Broad occupational orientation at the elementary and secondary levels, work experience, cooperative education and similar programs are funded under the Innovation Program.

During the period fiscal year 1970 to fiscal year 1972 Innovation Program obligations increased from $9.2 million to $14.6 million. Approximately thirty percent of these obligations went to rural areas.

For further information on the programs discussed in the above summary, see OMB, *Catalog of Federal Domestic Assistance*, June 1974.

13.493	Basic Grants to States
13.494	Consumer and Homemaking
13.495	Cooperative Education
13.498	Research
13.499	Special Needs
13.500	State Advisory Councils
13.501	Work Study
13.502	Innovation

D. Education of the Handicapped (Title VI)

The Education of the Handicapped under Title VI offers a variety of direct services, training, research and information programs. Benefits are available to handicapped children from preschool age through high school and range from direct diagnostic services to training for school instructors.

An important initiative in the area of direct services is the program to operate regional Deaf-Blind Centers to provide: (1) comprehensive diagnostic and evaluation services for all such children, a program for their education under their particular circumstances and effective consultative services for their parents and teachers. Centers are operated with project grants or contracts and may provide staff training, dissemination of information and construction as well. In fiscal year 1974, eleven regional centers coordinated their resources to provide educational services to 2,600 children. Obligations under this program were over $14 million in fiscal year 1974.

Another initiative for direct support to handicapped children is the Handicapped Preschool and School Programs. On a formula grant basis, funds are paid to state educational agencies, trust territories, the Bureau of Indian Affairs and other like agencies to assist them in the initiation, improvement and expansion of education services for handicapped children at the preschool, elementary and secondary school levels. During fiscal year 1973, an estimated 177,000 children participated directly in federally supported projects. Obligations for this program for fiscal year 1973 totaled $37.5 million.

Indirect aid to handicapped children through research on educational methods and training for parents and teachers is of vital importance to the education of handicapped children. Through the Research and Demonstration Program, eighty-nine projects to support research and related activities were accomplished in fiscal year 1973. The Handicapped Media Services and Captioned Films program maintains a free loan service of captioned films for the educational, cultural and vocational enrichment of the deaf. In addition it provides contracts for research on the use of media and media utilization. In fiscal year 1973, support was continued for thirteen Instructional

Media Centers, four Regional Media Centers, the Information Center on Exceptional Children, and the Instructional Material Reference Center at the American Printing House for the Blind. An audience of over 2.8 million benefitted from captioned films.

In order to facilitate the dissemination of information on both direct assistance to handicapped children and program availability to educational agencies, two programs are maintained. Handicapped Regional Resource Centers provide advice and technical services to educators for improving education of handicapped children. During fiscal year 1973, seven regional centers were supported with an obligated $7.2 million.

The Handicapped Teacher Recruitment and Information Program provides support to public or non-profit agencies to improve both recruitment of educational personnel and dissemination of information concerning educational opportunities for the handicapped. In fiscal year 1973, a referral system operating through health and welfare councils in nearly 100 cities nationwide was established, and $500,000 was obligated to operate the referral network.

Due to insufficient data, it is not possible to show the amounts of money obligated to rural and metropolitan areas separately for the Education of the Handicapped Programs. While most money is obligated for projects headquartered in metropolitan areas, it is estimated that program benefits derived are shared equitably between rural and non-rural areas. Local educational agencies receive the same information and may participate in various projects regardless of their location.

With a budget of $350,000 in fiscal year 1973, the Handicapped Physical Education and Recreation Research Program funded four projects to support research and related activities designed to improve physical education and recreational programs and methods for handicapped children. A companion program, Handicapped Physical Education and Recreation Training, provided training to almost 500 instructors. The objective is to improve the quality and increase the supply of personnel trained to work with the handicapped. Obligations in fiscal year 1973 were $700,000. The Handicapped Teacher Education program administers project grants to improve the quality and increase the supply of instructors trained to teach academic curricula to handicapped children. Grants may be used for undergraduate, graduate and summer traineeships. During fiscal year 1973, 6,100 students received direct support, and approximately 37,500 students graduated from grant supported programs. Another program, Special Programs for Children with Specific Learning Disabilities, provides both research and training for educational personnel in this specialized field. In fiscal year 1973, model projects were established and maintained in forty-three states, and a total of $2.8 million was obligated.

Available data does indicate that direct services for handicapped are distributed between rural and non-rural according to actual need with rural areas receiving proportionately about thirty-four percent of the total.

For further information on the programs discussed in the above summary, see OMB, *Catalog of Federal Domestic Assistance*, June 1974.

13.443	Research and Demonstration
13.445	Deaf-Blind Centers
13.446	Handicapped Media Services and Captioned Films
13.447	Handicapped Physical Education and Recreation Research
13.448	Handicapped Physical Education and Recreation Training
13.449	Handicapped Preschool and School Programs
13.450	Handicapped Regional Resource Centers
13.451	Handicapped Teacher Education
13.452	Handicapped Teacher Recruitment and Information
13.520	Special Programs for Children with Specific Learning Disabilities

E. EDUCATION PROFESSIONS DEVELOPMENT

Programs originally developed under the Education Professions Development Act were designed to meet two general needs: (1) to improve the quality of educational training programs, and (2) to improve the qualifications of education personnel especially in shortage fields such as individuals trained to work with exceptional children in regular classrooms.

Funding is primarily by project grant, usually to the State education agency (SEA) or local education agency (LEA). Institutions of higher education are also eligible for some grants. No match is required, but SEA's and LEA's are expected to gradually assume the burden of the programs as the Federal share is phased out. Program guidelines stress that Education Professions Development (EPD) funds should not be used to supplant existing or normal education activities.

Since 1970, total EPD program obligations have decreased considerably. The total of $87 million for fiscal year 1972 (down eight percent from 1970) has been further reduced in fiscal year 1973 and 1974. The decrease is the result of the gradual phasing out of the EPD programs. Existing programs are not funding any new projects, only continuations. The remaining EPD programs will be totally phased out by fiscal year 1976. The three Education Professions Development programs still in operation are directed at improving educational opportunities for children from low-income families and areas.

Education Personnel Training Grants-Career Opportunities fund low income residents and Vietnam Veterans to work as educational auxiliaries in poverty area schools while they train toward eventual teacher certification. Grants may be used to supervise, train, or better qualify persons who are serving or preparing to serve in elementary and secondary schools. Funds provide stipends, allowances, and instructional costs but may not be used for undergraduate programs.

Urban and rural schools characterized by concentrations of low income populations combined with low pupil performance and an inability to support change-oriented programs are eligible for Educational Personnel Development-Urban/Rural School Development grants. Money may be used to develop new programs for the development of educational personnel and in-service training of current personnel. Methodologies must be directed toward retraining strategies, curriculum reform and organizational innovation based on an evaluation of local needs. Such evaluations should be conducted on a collaborative basis involving school personnel, parents and the community in the process of educational change.

Established by Congress in 1965, Teacher Corps is a nationwide effort to give better educational opportunities to children from low-income families by improving the quality of teacher education programs for both certified teachers and inexperienced teacher interns. Teacher Corps gives school districts in low-income areas, their communities and nearby universities the opportunity to work together to plan and operate innovative two-year programs for better training and utilization of teaching resources.

Funds are provided to assist and encourage colleges and universities to develop and adopt programs of self-paced, competency-based teacher education. School systems receive monies to develop innovative teaching methods and outreach programs for the community. Colleges and school systems are provided funds to develop community based, volunteer-assisted programs such as youth tutoring and training of parents to offer educational help to their children. In the development of all these activities, colleges and schools must involve the resources of the community in program planning, administration and evaluation.

Nonmetropolitan areas received approximately twenty percent of the total funds obligated for the first two EPD programs. This share is about the same as in 1970. Urban areas receive the greatest share because it is the perception of program management that the problems of low-income are greater in inner cities.

Approximately thirty percent of the $35 million obligation for Teacher Corps was spent on nonmetropolitan university/school Teacher Corps programs in FY 1972 ($10.6 million). This figure represents a twelve percent increase in the proportion of funds spent in rural areas in FY 1970. Two reasons have been cited. First, during this interval funding was increased for Indian areas which are predominately rural. Second, colleges and universities in nonmetropolitan areas have become increasingly aware of their role in assisting their communities and providing opportunities through training to enable rural youth to stay in rural areas.

For further information on the programs discussed in the above summary, see OMB, *Catalog of Federal Domestic Assistance*, June 1974.

13.421 Educational Personnel Training Grants—Career Opportunities
13.489 Teacher Corps-Operations and Training
13.505 Educational Personnel Development—Urban/Rural School Development

F. SCHOOL ASSISTANCE IN FEDERALLY AFFECTED AREAS (IMPACT AID)

Two programs provide financial assistance to local education agencies upon which the Federal Government has imposed financial burdens. One program provides assistance for construction of urgently needed minimum school facilities in school districts which have had substantial increases in school membership as a result of new or increased Federal activities. Financial assistance is also provided where local educational facilities have been destroyed or seriously damaged as a result of a natural disaster. Project grants are administered on the basis of the increase in school children as a result of the Federal Government.

A second program provides financial aid for school maintenance and operation expenditures. Schools qualifying for assistance are those which have had a financial strain placed on them as a result of (1) a reduction in their tax base caused by Federal acquisition of real property, (2) a sudden and substantial increase in school attendance as a result of Federal activities, or (3) educating either children who reside on Federal property or parents employed on Federal property.

In 1972, a total of $550 million was obligated under the maintenance and operation program. The total was a slight increase of nine percent over the $508 million 1970 total. Rural areas received forty percent of the total in 1972. The large rural share is not surprising since much of the Federal activities (especially military) takes place in nonmetropolitan areas.

For further information on the programs discussed in the above summary, see OMB, *Catalog of Federal Domestic Assistance*, June 1974.

13.477	**School Assistance in Federally Affected Areas—Construction**
13.478	**School Assistance in Federally Affected Areas—Maintenance and Operation**

G. LIBRARIES AND COMMUNITY SERVICES

Under this category there are two types of programs. The first aids communities and educational institutions in the development of their library services and resources. A second assists communities in the solution of their problems by giving grants to universities and colleges to strengthen their community service programs.

The Library Services and Construction Act was enacted for the purpose of assisting States in the extension and improvement of public library services in areas where such services either do not exist or are inadequate. Title I of the Act awards formula grants to enable library services to be more accessible to persons who, by reason of distance, residence, physical handicap, or other disadvantage are unable to receive the benefits of public library services. Title I also gives grants to strengthen metropolitan public libraries which serve as national or regional resource centers. Each State is allotted a minimum amount plus additional funds based on the population of the State. The Federal share ranges from thirty-three to sixty-six percent.

Title III of the Act obligates formula grants for (1) planning and taking other steps leading to the development of cooperative library networks; and (2) for establishing, expanding, and operating local, regional, and interstate cooperative networks of libraries, which provide for the systematic and effective coordination of the resources of school, public, academic, and special libraries and information centers for improved supplementary services. Grants are administered by the same formula as those under Title I, except the Federal share is 100 percent.

Formula grants are made to States under Title II of the Act to aid in the construction of public libraries to serve areas without libraries.

The method used in distributing the grants is the same as that used under Titles I and III.

In 1972, rural areas received 15 percent, or $7 million, of the $46 million obligated to the Title I and III programs. The rural share of the total was unchanged from 1970, though the program increased by 30 percent from fiscal year 1970 to fiscal year 1972. Rural areas also received only 15 percent of the $8 million obligated to the construction program in fiscal year 1972.

Title II–A of the Higher Education Act of 1965 created a program to assist and encourage colleges and universities in the acquisition of library materials. Project grants are awarded on a formula basis. In 1972, $10 million was obligated, an increase of 4 percent from 1970. The rural share in 1972 was 33 percent.

The Library Training Grant Program, authorized by Title II–B of the Higher Education Act, assists colleges in training persons in the principles and practices of librarianship and information science. This program has no formula or matching requirements in the awarding of project grants. Total obligations decreased from $4 million in 1970 to $1.5 million in 1972. This decrease was in response to the administration's desire to de-emphasize the program. Since grants went only to higher education institutions, it is not surprising that rural areas received only 15 percent of the 1972 obligations.

The Higher Education Act also authorized a program to strengthen community service programs of colleges and universities. The programs are designed to assist in the solution of some basic community problems such as housing, poverty, recreation, employment, youth opportunities, transportation, health, and land use. Formula grants are made with the Federal Government providing two-thirds of the necessary funds for individual projects. The FY 1972 total obligation of $9 million was roughly the same as the FY 1970 total. The rural share remained constant at twenty-nine percent of the total.

For further information on the programs discussed above, see OMB, *Catalog of Federal Domestic Assistance*, June 1974.

13.406	College Library Resources
13.408	Construction of Public Libraries
13.464	Library Services—Grants for Public Libraries
13.465	Library Services—Interlibrary Cooperation
13.468	Library Training Grants

II. SPECIAL PROGRAMS AND PROJECTS

Programs included in this section are directed either toward a specific problem such as the elimination of illiteracy or at a specific target group such as Indians and other minorities. The programs are intended to supplement normal education programs rather than supplant them. Most are short-range, intended to be incorporated into curricula in the near future or to alleviate a problem so that future need will be obviated.

Emergency school assistance

The Emergency School Aid Act, Title VII of the Education Amendments of 1972, was designed to: (1) meet the special needs incident to the elimination of minority group segregation and discrimination among students and faculty in elementary and secondary schools; (2)

encourage the voluntary elimination, reduction, or prevention of minority group isolation in elementary and secondary schools with substantial proportions of minority group students; and (3) aid school children in overcoming the educational disadvantages of minority group isolation.

Funds for the seven Emergency School Assistance programs can be used for numerous activities. Included among these are remedial services, supplemental staff, teacher training and aids, guidance and counseling services, curriculum development, career education, interracial and community activities, support services, planning and minor school remodeling.

Temporary legislation authorized funds in Fiscal 1972 pending enactment of the Emergency School Aid Act. Thirty million dollars of a total seventy million obligation was allocated to rural areas. Two factors explain this large share. First, most of the court-ordered desegregation took place in the heavily rural areas of the South in 1972. Second, several of the programs were directed at multi-ethnic bilingual groups which would include migrants—another predominately rural group.

Authorization for expenditure of Emergency School Aid funds ceased at the close of fiscal 1974. At the present time, Congress has not proposed any extension of the legislation. Thus, there is no new money for project grants for Emergency Education programs.

Civil rights technical assistance and training

Established by Title IV of the Civil Rights Act of 1964, the Civil Rights Technical Assistance and Training Program is designed to facilitate the desegregation process by providing technical and training support to desegregating school districts.

Grants are made to local school boards to help them prepare and carry out desegregation plans, to give school personnel special in-service training, and to employ specialists in school desegregation problems.

Training institutes are authorized to improve the ability of school personnel to deal with special education problems. Teachers, school administrators, and school board members have been used to establish a series of school desegregation consultative centers at colleges and universities to make available trained personnel to help school districts with problems stemming from desegregation.

Although the focus is primarily at the local level, the program also provides support for State education agencies in order to facilitate their assistance to local school districts. State support includes advice and assistance regarding preparation, adoption, and implementation of desegregation plans, information about the most effective methods of dealing with the special problems of desegregating schools, and provision of qualified personnel from the Office of Education or outside sources for on-site assistance. The program provides project grants to local education agencies and both grants and contracts to institutions of higher education for training institutes.

There are no restrictions or guidelines which necessarily make assistance more relevant to metropolitan or nonmetropolitan areas. In terms of numbers, however, school districts served tend to be more nonmetropolitan because the districts required by law to desegregate are more often located in such areas. In terms of actual dollars, however, there are more resources applied in metropilitan areas.

In Fiscal 1972, rural areas received forty percent ($2.6 million) of the $6.5 million total program obligation. The nonmetropolitan percentage of the program increased five percent from FY 1970, although total program obligations decreased sixty percent. According to the Office of Education, this significant decrease in program obligations reflects a desire to de-emphasize technical assistance as a means of implementing the objectives of the Civil Rights Act.

Indian education

The Indian Education Act provides financial assistance for improving the educational opportunities of Indian children and for planning and implementing programs for Indian adults. Project grants may be used to support projects designed to plan for, test, and demonstrate the effectiveness of programs for improving educational opportunities for Indian children. Funds may also be used for evaluation and dissemination purposes.

Adult Indian Education encourages the establishment and operation of programs to stimulate the provision of basic literacy opportunities for non-literate Indian adults as well as high school equivalency opportunities in the shortest time feasible. Funds may also be used to encourage dissemination of information and materials related to and evaluation of the effectiveness of programs offering educational opportunities to Indian adults.

Grants are awarded to State and local educational agencies, Indian tribes, institutions and organizations, and to federally supported elementary and secondary schools for Indian children. Preference is accorded to Indian tribes and organizations. No matching funds are required.

Since roughly two-thirds of all Indians reside on reservations, the impact of these programs on nonmetropolitan areas of certain states with large concentrations of Indians is relatively large. The initial authorization for education of Indian children was approximately $5 million in FY 1973. Sixty-six percent, or $3.3 million, was estimated to have been awarded to school districts or organizations in rural areas. Four hundred and forty thousand dollars was authorized for adult Indian programs that same year with sixty percent, or $264,000, allocated to nonmetropolitan areas.

Right to read

The Right to Read Program is designed to provide facilitating services and resources to stimulate educational institutions, governmental agencies and private organizations to improve and expand their reading related activities.

The program is both an impetus to and a component of a national reading effort geared to eliminating functional illiteracy in the United States. Through this effort it is hoped that 99 percent of the population sixteen years old and 90 percent of the population over sixteen years of age will be functionally literate by 1980.

Funds are made available for planning and implementing exemplary programs, disseminating information related to effective reading techniques, teacher training practices, and conducting relevant surveys. Eligible grantees includes local education agencies. State education agencies, institutions of higher education and other appropriate public and private agencies. Project grants for school-based programs are based on a guideline of $600 per teacher directly involved in the program. Amounts for State education agencies and community-based programs are determined each year.

No data on Fiscal 1972 obligations is available since the program was first officially funded in 1973. Roughly $11.9 million was obligated that year, and the program is expected to continue at $12 million for the next two years.

Environmental education

Project grants are available under the Environmental Education Act of 1970 to any non-profit agency or organization to establish environmental education programs in schools and communities. The overall goal of environmental education programs is to enhance the quality of life in urban and rural areas by improving local understanding of existing environmental problems in addition to helping local authorities to do something about them with the assistance of schools and community environmental and conservation organizations and institutions.

Specific program initiatives in rural areas have included assistance for Alaskan Indians in their native villages to develop a program to enable them to make environmentally and economically sound land-claim choices; the design and conduct of environmental education workshops specifically focused on rural community problems; the development of an environmental awareness program for use throughout a rural state by a volunteer environmental coalition; and an environmental education program conducted by the Cooperative Extension Service for local community leaders in a Federal and State designated experimental ten-county model rural development district.

Grants for environmental education programs require a twenty percent local match for the first year of the project, forty percent the second year, and sixty percent during the third year of funding. Exceptions to this requirement include curriculum development, evaluation, information dissemination and small grants to private organizations.

Approximately eighteen grants totaling $388,342, or about thirty-two percent of the 162 fiscal year 1972 awards (total $1.2 million) went to nonmetropolitan areas for activities related to rural environmental problems. The relatively small rural share of the total is reflective of the initial belief that man-made environmental problems are primarily urban.

Drug abuse education

The Drug Abuse Education Act of 1970 is directed at helping schools and communities to assess and respond to drug abuse by becoming aware of the nature of the problem and developing strategies to overcome its causes rather than its symptoms. The objective of the program is two-fold: (1) to increase the capability of schools to respond to drug abuse through teacher training and the development and validation of curricular guidelines and materials; (2) to provide funds for demonstration, validation, and dissemination of community responses to drug abuse and users.

Of the $9 million obligated in fiscal year 1972 for non-matching project grants and contracts, nonmetropolitan areas received approximately twenty percent. This relatively low rural share reflects the predominant idea that drug problems are primarily urban. Presently, legislation for the program has expired. A new bill to continue the program is expected to be passed by Congress shortly.

For further information on the programs discussed in the above summaries, see OMB, *Catalog of Federal Domestic Assistance*, June 1974.

Emergency school assistance

13.525 Emergency School Aid Act—Basic Grants to Local Educational Agencies
13.526 Emergency School Aid Act—Pilot Programs
13.527 Emergency School Aid Act—Metropolitan Area Projects
13.528 Emergency School Aid Act—Bilingual Education Projects
13.529 Emergency School Aid Act—Special Programs and Projects
13.530 Emergency School Aid Act—Educational Television
13.532 Emergency School Aid Act—Special Programs

Civil rights technical assistance training

13.405 Civil Rights Technical Assistance and Training

Indian education

13.535 Indian Education—Special Programs and Projects
13.536 Indian Education—Adult Indian Education

Right to read

13.533 Right to Read—Elimination of Illiteracy

Environmental education

13.522 Environmental Education

Drug abuse education

13.420 Drug Abuse Education

I. National Institute of Education

The National Institute of Education (NIE) was created in 1972 with the broad legislative mandate to improve education so that every American is provided an equal opportunity to receive an education of high quality.

Proposed strategies for achieving this goal are: helping to alleviate or solve the problems and promote the reform and renewal of American education; advancing the practice of education as an art, science, and profession; strengthening the scientific and technological foundations of education; and building an effective educational research and development system. Education research activities as defined by NIE include basic and applied research, planning, evaluations, surveys, investigations, experiments and demonstrations including career education.

During Fiscal 1973, programs from the Office of Education and the Education Voucher Program from the Office of Economic Opportunity were transferred to NIE to serve as a base for the development of the Institute's activities. As a result of the review of these programs and an analysis of proposed new initiatives, the National Council on

Educational Research, NIE's policy-making body, adopted five priority areas as the central focus of the Institute's activities through fiscal year 1975. The major portion of NIE's programs, funding, and personnel resources will be concentrated in the areas of: (1) providing essential skills, such as reading, to all citizens; (2) improving the productivity of resources in education; (3) understanding and improving the relationship of education to work and careers; (4) improving the capability of State and local education systems to solve education problems; and (5) increasing diversity in American education.

While there are no restrictions in the Institute's funding provisions which would necessarily make assistance relevant to metropolitan or nonmetropolitan areas, the majority of the Institute's present activities are focused in metropolitan areas. NIE has highlighted a number of problems in nonmetropolitan areas to which current resources have been assigned.

Programs now underway having an impact on rural areas include the provision of improved communication techniques through use of communication satellite transmission; the development of educational materials for preschool-age children in isolated areas of Appalachia; vocational/technical training of unemployed, low-income families in rural areas; and the identification of local educational needs and problems and attempts to test and measure the capacity of schools for comprehensive change through the Experimental Schools program.

It is too early to adequately assess the data relative to NIE obligations in urban versus nonmetropolitan areas. Nevertheless, in Fiscal 1972, of approximately $65 million obligated to former Office of Education research and demonstration programs that were subsequently transferred to the National Institute of Education, only five percent was obligated to rural areas. The figures for FY 1970 were roughly analogous. Such proportion bears out NIE's own admissions, since most research is conducted at sophisticated university complexes, most of which are located in metropolitan areas. Preliminary data for Fiscal 1973 seem to indicate that the share of funds for demonstration activities in rural areas may be considerably greater, primarily as a result of the specific activities mentioned above. One in particular, the communications satellite, is an especially expensive project despite the fact that costs are being shared with several other agencies, including the National Aeronautics and Space Administration.

For further information of the program discussed in the above summary, see OMB, *Catalog of Federal Domestic Assistance*, June, 1974.

13.575 Educational Research and Development

Chapter IV

OFFICE OF THE SECRETARY PROGRAM ANALYSES

The Department is supervised and directed by the Secretary who is appointed by the President and confirmed by the Senate. The Secretary is assisted in overall management by an Under Secretary, eight Assistant Secretaries, a General Counsel and ten agency heads. In 1973, the Office of the Secretary underwent some organizational changes that affected the Public Health Service, Social and Rehabilitation Service, eliminated the Office of the Assistant Secretary for Community and Field Services and created the Office of Assistant Secretary for Human Development. Beyond the Under Secretary, the major offices currently represented within the Office of the Secretary include:

General Counsel
Office of Civil Rights
Assistant Secretary, Public Affairs
Assistant Secretary for Human Development
Assistant Secretary for Health: Food and Drug Administration, National Institute of Health, Health Resources Administration, Center for Disease Control, Alcohol, Drug Abuse and Mental Health, Administration
Assistant Secretary, Legislation
Assistant Secretary for Planning and Evaluation
Assistant Secretary for Administration and Management
Assistant Secretary, Comptroller
Assistant Secretary for Education: Commissioner of Education; National Institute of Education
Social Security Administration

Regional offices

The Department maintains ten regional offices, each headed by a Regional Director who acts on behalf of the Secretary. The Regional Directors represent the Department with state, local and institutional officials and carry out departmental policies and provide leadership, coordination, evaluation and general administrative supervision of all representatives located in the regional offices. Regional Directors also have responsibility for review of any field activity operated out of the Department and impacting on their respective regions, particularly in the areas of public and intergovernmental relations.

A. Civil Rights Compliance Activities

The Department of Health, Education, and Welfare is responsible for assuring that beneficiaries of major Federal programs receive

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services without discrimination or segregation. Within the Department, the Office of Civil Rights (OCR) is responsible for enforcing Title VI of the Civil Rights Act of 1964, Executive Order 11246, Titles VII and IX of the Education Amendments of 1972, Sections 799A and 845 of the Public Health Service Act, and Section 504 of the Rehabilitation Act of 1973.

Title VI of the Civil Rights Act of 1964 states that no person shall be discriminated against because of his or her race, color, or national origin in any program or activity that receives Federal financial assistance. It adds that no Federal assistance can be extended to any activity in which there is discrimination on the above grounds. Since HEW administers three of the largest Federal programs—public assistance, aid to education, and public health services and research—in addition to other financial assistance under Federal grant and loan programs, the Department is the major agency affected by Title VI.

The Office of Civil Rights also has enforcement responsibilities for two laws and one executive order regarding sex discrimination. Executive Order 11246 bans discrimination in employment on the basis of sex and religion, in addition to race, color, or national origin on federally assisted construction projects and by Federal contractors. Titles VII and IX of the Education Amendments of 1972 require that educational institutions, with certain exceptions, must offer all their benefits and services without regard to sex in order to be eligible for Federal assistance. The Comprehensive Health Manpower and Nurse Training Act of 1971 also contains provisions barring sex discrimination in the admission of individuals to health training programs benefiting from certain types of Federal financial assistance. Sections 799A and 845 apply to any school of nursing, medicine, osteopathy, dentistry, veterinary medicine, optometry, pharmacy, podiatry, public health, or any training center for allied health personnel.

Another anti-discrimination provision administered by the Office for Civil Rights is contained in the Rehabilitation Act of 1973 (Section 504). This provision prohibits discrimination against physically or mentally handicapped individuals in Federally assisted programs. Such programs are required to provide equal opportunity and service to handicapped individuals.

All agencies and institutions receiving Federal assistance must submit prior assurances that they will comply with these laws and the regulations issued by the Department. If a recipient reneges on this commitment of compliance or refuses to make a commitment, Federal assistance may be discontinued. Any individual who feels he or she has been discriminated against in the provision of services may file a complaint or grievance either with the Office for Civil Rights or the Equal Employment Opportunity Commission. OCR will investigate and take corrective steps to assure equal opportunity.

Many of the activities of the Office for Civil Rights have been concentrated on although not limited to day care centers, elementary schools, colleges, hospitals, and nursing homes. These services are vital to the functioning of federally assisted programs in nonmetropolitan areas as well as in urban areas.

For additional information on the program discussed in the above summary, see OMB, *Catalog of Federal Domestic Assistance*, June, 1974.

13.602 Civil Rights Compliance Activities

B. SURPLUS PROPERTY UTILIZATION

Departments and Agencies of the Federal Government continually find that as a result of changes in program requirements, obsolescence, and technological developments, they own real and personal properties which are excess to their needs. The Federal Property and Administrative Services Act provides an orderly process whereby such excess properties, both real and personal, are screened against the needs of all Federal Agencies. Property is then made available for donation to eligible educational, public health and civil defense donees in the United States, its territories and possessions.

Surplus personal properties are donated to public or tax-exempt nonprofit private medical institutions, schools or school systems, colleges and universities, schools for the mentally retarded and physically handicapped, licensed educational radio and television stations, and public libraries. Real property can go to States, their political subdivisions and instrumentalities, tax-supported or nonprofit tax-exempt educational and medical institutions, and hospitals or similar institutions.

HEW is responsible for allocating surplus personal properties to the designated agency in each State for distribution and donation to eligible beneficiaries. Surplus real properties are offered for transfer at a public benefit discount to eligible public health and educational institutions in each State.

The Office of Surplus Property Utilization has the responsibility for locating available surplus properties needed and usable and for allocating available properties on an equitable basis to the fifty-three State Agencies (including the District of Columbia, Puerto Rico and the Virgin Islands). These functions are administered and conducted by Regional Offices. The ten Regional Offices then provide the State Surplus Property Agencies with catalogs, bulletins and newsletters about available property. This information enables the State Agency and its donees to have knowledge of available property and to submit requests through HEW's Regional Offices.

State Agencies maintain one or more major warehouse distribution centers for display of surplus property. Representatives of donee institutions are permitted to visit these centers to inspect and request acquisition of needed properties. Institutions acquiring surplus property pay a nominal service and handling charge to reimburse the State Agency for the costs of acquiring the property and general overhead expenditures. Agencies and institutions must also pay all costs associated with moving the property from the distribution center to its final destination.

Sometimes a surplus item or parcel of land can fill a need "as is." For instance, in hospital and health facilities, computers and electronic equipment only need a change of ownership to be put to use. Where surplus property cannot be used in its original form, a simple metamorphosis can often make it the raw material of community development. Little needs to be done to make a classroom out of a quonset hut, or a college dormitory out of an Army barracks building. Surplus property is of inestimable value for direct use or conversion for use of its components or parts. Vocational and academic programs materially benefit. About ninety percent of Federal surplus property comes from the Department of Defense. The remainder largely comes from the Atomic Energy Commission, Veterans Administration, HEW, Agriculture, Interior, and the General Services Administration.

Between 1946 and 1973, surplus real and personal properties having an original acquisition cost of 8.6 billion were transferred to eligible institutions. Surplus property is allocated to the States on the basis of per capita wealth and State population index. Consistent effort is made to provide all States with an opportunity to acquire their share of available properties. However, economically advantaged communities participate less than rural or other more needy areas.

The surplus property program is an outstanding example of revenue sharing through which the Federal Government provides land, buildings, equipment and supplies to States for the improvement of their public health, educational and civil defense facilities. It encourages local initiative and improved cooperation among all levels of government and enables economically disadvantaged areas to provide programs and facilities for their people which would otherwise be unavailable. The system of surplus property distribution is a channel for Federal aid which has a significant potential for rural areas.

For further information on the program discussed in the above summary, see OMB, *Catalog of Federal Domestic Assistance*, June, 1974.

13.606 Surplus Property Utilization

C. FACILITIES ENGINEERING AND PROPERTY MANAGEMENT

There are about thirty-five health, education, and rehabilitation construction programs within HEW expending annually about $1 billion and generating a total construction expenditure of about $4 billion. Projects are located in rural as well as in metropolitan areas.

Through ten regional offices, Facilities Engineering and Construction staffs provide a single point of contact for State and local agencies and private institutions on the architectural/engineering development and evaluation of proposals for health, education and rehabilitation-type facilities. The guidance and direction provided by the engineering staffs is supportive of programs funding those types of facilities and is independent of the services of a grantee's private architect/engineer. Primary concerns of the Office of Facilities Engineering and Construction include:

(1) Improvement of health and education facilities design and construction;

(2) Development of HEW Department-wide design standards;

(3) Reduction of costs and improved flexibility as made possible by advanced building techniques; and

(4) Adherence to Federal requirements such as competitive bidding.

The Office of Facilities Engineering and Construction has developed a concept of "value engineering" which is an organized effort to achieve the required function at the lowest total cost. Professional workshops have been planned in relevant program areas to implement the facilities management system. Interested persons should contact the HEW Regional Office of Facilities Engineering and Construction for further information. Also, see OMB *Catalog of Federal Domestic Assistance*, June, 1974.

13.607 Facilities Engineering and Property Management—Technical Assistance

Office of Human Development

The Office of Human Development (OHD) was created through Secretarial reorganization in April, 1973. The Office seeks to organize HEW's planning capacity and resources more effectively for certain groups of "vulnerable" Americans with special needs. Formerly scattered throughout the Department, eight agencies and offices have been consolidated within OHD to impact on children and youth, the aged, mentally retarded and other handicapped persons, Native Americans and people living in rural areas.

Four of the eight agencies operate significant grant programs, in addition to acting as advocates and coordinators of Departmental and government-wide services. They are: the Office of Child Development, the Office of Youth Development, the Administration on Aging, and the Office of Native American Programs. The remaining five agencies have advocacy and program coordinating responsibilities for the vulnerable populations they represent. They are: the Office for the Handicapped, the Office of Rural Development, the President's Committee on Mental Retardation, the President's Council on Physical Fitness and Sports, and the Office of Manpower Coordination.

D. Administration On Aging

In 1972, almost 1.2 million older couples (those whose household heads were age sixty-five or older) had income under $3,000 per annum ($58 per week). In addition, there were about 1.3 million single persons over age sixty-five living alone or with nonrelatives who had incomes under $1,500 per annum ($29 per week). The number of older people in our population is growing at a rapid pace. In 1900, there were fewer than four million Americans age sixty-five or over. By 1972 the number had grown five fold to twenty-one million. If present population trends continue, there will be twenty-nine million older Americans in 2000. Their percentage of total population has grown from four percent in 1900 to ten percent in 1970 and is expected to be eleven percent by 2000.

A number of salient facts concerning older Americans were presented in the report of the Special Concerns Session on the Rural Elderly, 1971 White House Conference on Aging. There are nearly nine million older Americans living outside metropolitan areas. Rural elderly make up forty-one percent of the total elderly population.

Nearly thirty-three percent of the men have incomes of less than $2,000 annually while fewer than five percent earn $10,000 or more. For older women, the figures are seventy percent and one percent respectively. One-third of all rural elderly persons live in poverty compared with twenty-five percent in central cities and seventeen percent in suburban areas.

Many rural elderly persons are isolated from their neighbors and available services by poor roads and lack of transportation. Sixty percent of substandard housing units are in rural areas. About twenty-five percent of these are occupied by elderly people of which nine out of ten have incomes below the poverty level. Rural elderly have more chronic health conditions than their urban cousins. Disabled rural elderly are disadvantaged by a scarcity of doctors and lack of transportation to medical facilities. The result is that their health needs tend to be neglected.

Through the Administration on Aging (AoA), HEW is trying to meet the needs of older people in their home communities, rural as well as urban. This agency was created by the Older Americans Act of 1965, as amended, and administers programs authorized by that Act. AoA efforts are directed in three major areas: (1) Grants for State and Community Programs on Aging; (2) Grants for Training and Research; and (3) the Nutrition Program.

Grants for State and Community Programs on Aging

Title III of the Older Americans Act of 1965, as amended, is a Federal-State formula grant program to encourage and assist State and local agencies to concentrate resources in order to foster the development of comprehensive and coordinated service systems to serve older persons. The overall objective of the Title III program is to strengthen or to develop at the sub-State or area level a system of coordinated and comprehensive services, which will enable older people to live in their own homes or communities as long as possible.

In order to participate in this program, State agencies must prepare and execute an annual State operating plan which includes plans for implementation of steps towards comprehensive and coordinated services for older people in the States, and evaluation of progress toward that objective. A comprehensive and coordinated service delivery system, as defined in regulations, is one which provides all necessary social services in a manner designed to:

> Facilitate accessibility to and utilization of all social services within the geographic area served by any public or private agency or organization,
>
> Initiate, develop, and make the most effective use of social services in meeting the needs of older persons,
>
> Use available resources efficiently and with a minimum of unnecessary duplication.

The aforementioned plan must first receive approval by the Governor of the State and then be submitted to the Commissioner on Aging for his approval. In implementing the plan, a State agency must first divide the entire State into planning and service areas, taking into consideration the geographical distribution of persons aged sixty years or older in the State (including the number of low-income and minority elderly), the need for social services and the distribution of resources to meet such need, the boundaries of existing areas within the State drawn for planning or administration of social services programs, and the location of units of general purpose local government within the State.

The State agency must then designate Area Agencies on Aging to develop and implement area plans for a selected number of planning and service areas within the State. Area plans are then submitted by the Area agencies to the State agency for approval, and upon such approval, become part of the annual State operating plan. Each Area Agency on Aging is charged with the following major responsibilities:

To become a focal point for leadership in the field of aging for its planning and service area.

To engage in a continuous process of planning in order to define or redefine objectives and to establish priorities and develop a system designed to improve the delivery of services.

To make provision for an action program designed to coordinate the delivery of existing services for older persons.

To make provision for an action program designed to pool available but untapped resources from both the public and private sectors in order to strengthen existing or to inaugurate new services.

To take steps, in cooperation with State Agencies on Aging, designed to achieve the establishment or maintenance of information and referral sources in sufficient numbers to assure that all older persons within the area will have reasonably convenient access to such sources by the end of Fiscal Year 1975.

To enter into contracts or to make grants for inaugurating or strengthening supporting and gap-filling services for older persons.

To monitor and assess and conduct periodic evaluations of activities carried out under its auspices.

To develop comprehensive and coordinated programs for older persons throughout the planning and service area.

Transportation is one of the services permitted under Title III, that are aimed at maintaining independent living, especially in rural areas. In many communities, point-to-point transportation is made available to the elderly to make it possible for them to receive necessary care and participate in social and recreational activities.

Health related services also help older persons to continue to maintain independent living. Home visits by nurses under the direction of a physician, and by homemakers/home health aides under the supervision of a registered nurse, provide nursing and personal care as well as light housekeeping. Other community health services are health education, geriatric screening and referral, and immunization programs.

Volunteers, many of whom are elderly themselves, assist in providing such services as friendly visiting, telephone reassurance, teaching adult education courses to other older persons, and in the preparation and delivery of meals. Many are also involved in the planning of community activities and services for the elderly.

Under Title III, State agencies on aging have provided support for senior centers which were located in housing projects, churches, other public and private buildings, and in some institutions. Some of these senior centers have established satellite centers to enable the elderly in less densely populated areas to participate in their activities.

As of early 1973, the Administration on Aging estimated that forty-three percent of the community programs were located in rural areas and fifty-seven percent in urban areas.

The Older Americans Comprehensive Services Amendments of 1973, established a new Model Project Program. The Commissioner on Aging is authorized to enter into contracts with or to make grants to any public or non-profit private agency or organization within a State to pay part or all of the cost of developing or operating statewide, regional metropolitan area, county, city or community model projects which will expand or improve social services or otherwise promote the wellbeing of older persons.

The objectives of the projects are: (1) to use the talents of senior citizens as educational aides; (2) to provide enrichment and service programs for senior citizens; (3) to develop a talent bank of senior citizens; (4) to provide training to agency personnel; (5) to develop a university curriculum for students who wish to work with aging; and (6) to establish a service corps of retired executives. Special consideration is to be given by the Commissioner to those projects designed to assist in meeting the special housing needs of older persons, provide continuing education, provide pre-retirement education, information, and relevant services to those planning retirement, or provide services to assist in meeting the particular needs of the physically and mentally impaired older persons to assist such individuals in leading more independent lives.

Grants for training and research

Under Title IV, Part A, of the Older Americans Act, funds have been made available to the State Agencies on Aging in fiscal year 1974 to support short term training activities which are conducted in accordance with proposals developed by the State Agencies.

Training priorities include the development of programs in selected areas to augment the AoA-developed training for State and Area Agency and Nutrition Program staff. Training content may include: gerontology; implications for older persons of transportation, housing, health, and recreation systems planning; evaluation, coordination; program management and analysis; information and referral skills, including use of information systems; nutrition; food service and management; data collection, analysis, and utilization; budgeting and financial management; public information; basic writing skills; and any other content designed to meet the special needs of staff related to Titles III and VII.

Training is also provided for staff of local Title III supported programs which are coordinating with State and area agencies, and for other persons serving the elderly. Short-term training may be supported for persons concerned with or serving older persons, including but not limited to community health and mental health staff, homemakers, senior center staff, legislative personnel, clergy and religious workers, those engaged in retirement planning, and adult educators preparing to teach older persons.

Research

Title IV of the Older Americans Act of 1965 authorizes grants and contracts for training and research programs to meet the challenges of aging. Some research and development projects funded under this authority have been designed to test and demonstrate new approaches toward meeting the needs of the rural elderly such as information and referral services, and needs assessment strategies.

Nutrition program

Title VII of the Older Americans Act of 1965, as amended, authorizes a nutrition program for the elderly. This program is designed to meet the nutritional and socialization needs of individuals, aged sixty and older, who do not eat adequately because (1) they cannot afford to do so; (2) they lack the knowledge and/or skills to select and prepare nourishing and well-balanced meals; (3) they have limited mobility which may impair their capacity to shop and cook for themselves; or (4) they have feelings of rejection and loneliness which may obliterate the incentive to prepare and eat a meal alone. The purpose of the program is to provide older Americans, particularly those with incomes below the Bureau of Census poverty threshold, with low-cost, nutritionally sound meals served largely in congregate settings at strategically located centers.

As of June 7, 1974, 664 Title VII nutrition projects have been approved, of which 213 are considered rural projects. In the 664 projects, the average number of daily meals being served on that date was 191,227, of which 124,754 were being served to persons below the poverty threshold. Of the 191,227 average number of daily meals, eighty-eight percent were being served in congregate settings, and twelve percent were being delivered to participants in their homes.

For further information on the programs discussed above, see OMB, *Catalog of Federal Domestic Assistance*, 1973.

13.756 Special Programs for the Aging

E. OFFICE OF CHILD DEVELOPMENT

Head Start

The Head Start program is funded by the Office of Child Development. Head Start is a program of comprehensive services to preschool children and their families, primarily those who are low-income. Community Action Agencies maintain priority for the operation of the Head Start program and may operate it directly or delegate portions of the program. Technical assistance and training are provided to local Head Start programs to enhance the quality and effectiveness of services offered. Through a large winter program and a small summer program, children receive preschool preparation designed to raise their social competence to that of other children they will meet in school.

The provision of Head Start in rural areas presents several problems. Transportation, for one, is critical in that children must be transported to the center. Another problem is that of obtaining specialized types of program assistance—doctors, nutrition specialists, etc. In some rural areas, parents are reluctant to send their children to a Head Start Center. These parents must first be made aware of the benefits of preschool preparation and group participation before a Head Start Center can be successful. As of FY 1973, there were 1,545 Head Start programs in the United States including Parent and Child Centers. Approximately forty percent, or 618 programs, were in rural locations. At least ninety percent of Head Start children come from low income families.

There are two categories of Head Start programs: Those which run virtually all year and those which run eight weeks during the summer. The summer program is designed for pre-kindergarten or pre-elementary school children, age 4–6, while the full year program is designed for children age 3–6 from very poor families who might otherwise not reach an adequate social competence level to compete with other children in school. In FY 1973, the average cost per child in the summer program was $226 while the cost for a full year child was $1,180.

Grants are generally made the Community Action Agency programs with a local agency providing twenty percent and the Federal Government providing eighty percent of all operating expenses. The local contribution may be in cash or services. Retired men and women are a main source of volunteer help in rural Head Start programs. Involvement of volunteer adults in the operation of the center often leads to the best results for the children.

During the period FY 1970 to FY 1972, the Federal budget for Head Start increased from $325.7 to $376.3 million. For FY 1975, a budget of $430 million will support programs serving an estimated 379,000 children.

Parent and child centers

In recognition of the increasing evidence that a child's potential is shaped in infancy, and even during the prenatal period, the Parent and Child Center program began a limited pilot program for ages 0–3. The Parent and Child Centers program is also aimed at low-income families. It is comprehensive in character and may provide for testing the children for medical defects, training for parents in the areas of child care and group play activities. Medical costs for a child's mother may also be paid if her disability is preventing proper care for the child.

No specific model has been suggested for the Parent and Child Centers program. Rather, new and different designs are encouraged in order to test the effectiveness of varied methods. One essential feature of each center is that the parent beneficiaries help plan and carry out their program.

Research and demonstration

The Office of Child Development also administers the Research and Demonstration program funded under Section 426 of the Social Security Act. The program provides financial support for special research and demonstration projects which are of regional or national significance in the field of child welfare. Grants may be made to public or private non-profit agencies or other organizations engaged in research or child welfare activities. The Federal share of these grants is ninety-five percent.

A number of grantees are currently involved in research or demonstration projects in rural areas. Areas such as the provision of day care, child abuse and neglect, treatment and prevention, child advocacy, and education for parents are being studied.

Child abuse prevention and treatment

The Office of Child Development assumed responsibility for the administration of the Child Abuse Prevention and Treatment Act in January 1974. The Children's Bureau, within OCD, is charged with the responsibility for this program which includes: (1) research into the causes of child abuse; (2) training teachers, nurses and others who come in contact with children to recognize child abuse and to treat the children medically, psychologically and socially; (3) gathering data on the child abuse problem; (4) publishing an annual report on the subject, and (5) serving as a national information clearinghouse.

For further information on the programs discussed in the above summary, see OMB, *Catalog of Federal Domestic Assistance*, June 1974.

13.600	Child Development—Head Start
13.601	Child Development—Technical Assistance
13.608	Child Development—Child Welfare Research and Demonstration Grants

F. OFFICE OF NATIVE AMERICAN PROGRAMS

The mission of the Office of Native American Programs is to assist American Indians, Eskimos, Alaska Natives, and Aleuts in attaining economic self-sufficiency through a policy of self-determination in which Indian people establish their own priorities and control or direct the institutions and programs which affect their daily lives.

In support of this mission, the Office of Native American Programs (ONAP), transferred from OEO in July 1973, provides financial and technical support to tribal councils and other Indian groups and organizations. In addition, ONAP is the Office within HEW which assesses the effectiveness of the Department's policies and programs for Native Americans and advises the Secretary in these matters.

It is estimated that there are in excess of one million Indians affiliated with over 600 different tribal groups living in the United States. Amid the distinctions between tribal entities and individual enrollments and allotments, the eligibility requirements often tied to various Federal services are vague. The Office of Native American Programs has legislative authority to serve all Indian groups and entities; eligibility requirements are based on need alone, not on geographic location.

Budget constrants, however, limit office services to approximately 450,000 Native Americans on 154 reservations in thirty-six States and fifty-two off-reservation programs. Eighty percent of the Indians served fall within the Federal poverty limit. ONAP grants range from $10,000 to $5 million, with the average grant being about $130,000. Funds are generally used for but not limited to three kinds of activities: general community programming, training and technical assistance, and research and demonstrations. As a general rule, twenty percent non-Federal funds are required. Exceptions to this provision may be made for grantees serving low income communities according to ability to pay.

General community programs include such projects as senior citizens centers, family planning, food and nutrition programs, Indian owned and operated housing construction companies, economic development programs, and services in urban/off-reservation areas for employment, counseling, and training

Based on a sample taken in fiscal year 1973, grantees receiving funds for community programs placed their highest priority on economic development—principally jobs. Following in order of priority were tribal management, food and nutrition programs, adult education and arts and crafts development.

Within a budget of $30.9 million, the Office of Native American Programs awarded approximately 150 grants and contracts to Indian groups in fiscal year 1974. Roughly two-thirds of these funds were granted to tribal governments on 154 reservations. Most grantees carried out more than one type of activity, and certain efforts were given higher priority by those grantees. Many reservations used ONAP funds as a catalyst to attract other Federal and State programs and to fill gaps in categorical programs. Funds totaling $3 million were used to maintain thirty-five urban centers transferred from the Office of Economic Opportunity and to establish new centers. The focus of this funding has been to develop a system of linkages with local, State and Federal resources leading to more adequate provision of services to off-reservation Indians located in metropolitan areas.

A training and technical assistance program is primarily geared to aiding tribal governments in areas such as special management assistance and program assistance (program compliance). The objective of the training and technical assistance program is to apply limited resources to those needs of grantees that are actual, urgent and will have the greatest multiplier effect in leading to self-sufficiency. Included in this objective are such activities as the: (1) Provision for a set-aside of flexible resources to be used in support of other offices and agencies which lack planning capability; (2) Creation of opportunities for career development for grantee Indian staff; and (3) Provision of training activities that leave behind management systems that are self-sustaining. The principal goal of this effort is to advance the governmental capacity of tribes and improve the quality of services to off-reservation Indians.

Research and demonstration activities in fiscal year 1974 totaled $2.4 million. The emphasis here was on exploration of the economic development potential of reservations, since such efforts can provide long-range employment opportunities, establish management capabilities, and improve the overall economic climate for reservation Indians.

The 1975 objectives of the Office of Native American Programs were developed in concert with Indian leaders around the concerns of Indian people, both on and off reservations. The long-range goals of ONAP will continue to emphasize flexible assistance for achieving self-determination by Indian tribes and organizations and promoting continued progress toward economic and social self-sufficiency.

For further information on the programs discussed in the above summary, see OMB, *Catalog of Federal Domestic Assistance*, June 1974.

13.612 Native American Programs

G. Office of Youth Development

"Juvenile delinquency" generally refers to youths who have behaved in a manner which resulted in their being processed by the juvenile justice system. It is a problem which cuts across demographic boundaries and touches families and children from all strata of society. DHEW's "Juvenile Court Statistics, 1972" indicates that in that year delinquency cases decreased for the first time since 1961. The decrease from the previous year was less than one percent while the youth population, ages ten through seventeen, increased by less than one percent from 1971. This represents a reversal of the trend in recent years for cases to not only increase each year, but for the rate of increase to exceed that of the total youth population.

While almost fifty-one percent of delinquency cases were handled non-judicially in 1972 (i.e., without the filing of a petition), non-judicial handling was more prevalent in urban and semi-urban courts than in rural courts. The latter, which account for seven percent of the nation's delinquency cases, have less judicial handling because they generally have less specialized intake or probation staff than courts in larger metropolitan areas.

The Juvenile Delinquency Prevention Act of 1972 (P.L. 92–381), changed the Office of Youth Development's program direction from support of small categorical grants to a comprehensive juvenile delinquency prevention approach. The Office is directing its resources into two major efforts, Youth Delinquency Prevention, and Youth Participation.

Youth delinquency prevention involves three areas of activity. Support is provided to "systems building,"—helping communities identify weaknesses in youth service delivery. Possible gaps in the total youth service delivery system are noted, and ways of filling the gaps are suggested. Another activity, "capacity building," involves identifying ways community leaders can coordinate their efforts in order to enhance the overall effectiveness of youth services. By eliminating needless duplication and increasing referrals, the capacity to serve can often be improved. The third area is the removal of "institutional barriers" to effective youth services. Draft legislation for family courts and law enforcement/juvenile court intake screening guides will suggest the best handling of juveniles for diversion from the juvenile justice system. These three areas of OYD activity are based on the premise that by providing a comprehensive array of youth services and quick referral to the appropriate service agency, a community can achieve a major reduction in the number of repeat offenses.

OYD's second major effort is youth participation. This initiative is aimed at increasing youth participation in the process of developing youth programs. This is based on the premise that more effective youth programs can be developed if some of the ideas of the program beneficiaries are incorporated in the planning process.

Project grants are made for the development and implementation of coordinated youth service systems and technical assistance to agencies and organizations involved in operating delinquency prevention programs. Initial grants are given for one year and may be renewed for a second year but not to exceed two years. The Federal share of funding for youth service systems is seventy-five percent.

In fiscal year 1970, total program obligations amounted to approximately $9.8 million, and of this $3.1 million or thirty-one percent went to nonmetropolitan areas. Data for fiscal year 1972 indicates a similar breakdown of the same total.

For further information on the programs discussed in the above summary, see OMB, *Catalog of Federal Domestic Assistance*, June 1974.

13.610 Youth Development and Delinquency Prevention

H. OFFICE FOR THE HANDICAPPED

The creation of the Office for the Handicapped (OFH) was announced on February 20, 1974. It was formed to implement the provisions of Section 405 of the Rehabilitation Act of 1973. OFH provides a focal point within DHEW for review, coordination, and planning related to policies, programs, procedures and activities within DHEW and other Federal agencies relevant to the physically and mentally handicapped. OFH will: (1) prepare a long-range projection for the provision of comprehensive services to the handicapped; (2) continually analyze the operation of programs for the handicapped and evaluate their effectiveness; (3) encourage coordination and cooperative planning among programs serving the handicapped; (4) develop ways to promote the utilization of research related to the handicapped; and (5) provide for a central clearinghouse for information and resources available to handicapped people.

Although OFH is not funded for programs of its own, its role as coordinator and analyst of existing Federal programs for the handicapped will be invaluable for directing future programs to where the greatest needs exist. The fiscal year 1975 budget covers administrative costs only.

I. THE OFFICE OF RURAL DEVELOPMENT

The Office of Rural Development in HEW was created in June, 1973, to "catalyze and institutionalize throughout the Department a concern for meeting the needs of rural Americans." Located within the Office of the Assistant Secretary for Human Development, the Office provides a locus for rural concerns and provides the Department with an official link with other executive departments in support of Section 603(b) of the Rural Development Act of 1972. Section 603(b) specifically addresses the need for intergovernmental coordination and directs the Secretary of Agriculture ". . . to provide leadership and coordination within the executive branch and assume responsibility for a nationwide rural development program utilizing all agencies of the executive branch in coordination with rural development programs of State and local governments."

The stated Secretarial mandate for the Office covers four specific areas of activity:

> To identify barriers to the delivery of HEW services in nonmetropolitan areas;
>
> To design and recommend human service delivery systems for rural areas;
>
> To establish an internal rural network and coordinate those efforts with other Federal agencies for the purpose of delivering human services to target areas;
>
> To represent the Department on interdepartmental task forces concerned with rural development.

The Office of Rural Development is not an operating agency and has no program budget. Instead, it is organized to impact on the various sets of processes within HEW related to rural development. Examples of such processes include intergovernmental relations, intradepartmental coordination, policy development, information sharing and capacity building through training and technical assistance.

Activities during its first year of operation included: (1) the establishment of a departmentwide rural network through the identification of a formal liaison in each Regional Office and major agency; (2) a study of a select number of projects from which the Office expects to describe principal barriers to human service delivery, to set procedures for evaluating such delivery systems, and to extract characteristics of "successful systems;" (3) the preparation of a report on HEW financial obligations to nonmetropolitan areas and submission for publication to the Senate Subcommittee on Rural Development; and (4) the contracting for an evaluation of Concerted Services in Training and Education, a manpower and community development program devoted solely to rural areas.

CHAPTER V

SOCIAL AND REHABILITATION SERVICE

The Social and Rehabilitation Service (SRS) was created in 1967, through a Secretarial reorganization. It administers programs providing technical, consultative and financial support to States, local communities, other organizations, and individuals in the provision of social services, rehabilitation, income maintenance, medical assistance, families and child welfare, and other necessary services to the aged and aging, children and youth, the disabled, and families in need.

In April, 1973, two offices, the Administration on Aging and the Youth Development and Delinquency Prevention Administration were transferred to the newly created Office of Human Development, located within the Office of the Secretary. The programs that remain in SRS are administered by the Assistance Payments Administration, Community Services Administration, Medical Services Administration and Rehabilitation Services Administration.

A. GRANTS TO STATES FOR PUBLIC ASSISTANCE AND COMMUNITY SERVICES

Income maintenance

Prior to 1974, public assistance programs included Old Age Assistance, Aid to the Blind, Aid to the Permanent and Totally Disabled and Aid to Families with Dependent Children. Effective January 1, 1974, public assistance payments for the adult categories were absorbed into a new program, the Supplemental Security Income (SSI) for the Aged, Blind, and Disabled program, which is administered by the Social Security Administration under Public Law 92-603.

The remaining program of Federally aided public assistance cash payment to States—Aid to Families with Dependent Children (AFDC)—partially reimburses States for expenditures to needy families with dependent children. These payments are made to eligible recipients by State or local welfare agencies under an HEW approved State plan.

AFDC is directed toward helping families in which there has been a loss of financial support because of the death, continued absence or incapacity of a parent, or, optionally, the unemployment of the father. To receive Federal funds the program must be in effect statewide, and Federal requirements for eligibility must be met in the State plan. Within broad Federal standards, each State determines the amount of its payments and eligibility requirements.

Total AFDC obligations in fiscal year 1972 were $3.6 billion, approximately fifty-five percent above the $2.3 billion total for fiscal

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year 1970. The large increase during this two-year period is the result of a large number of people utilizing AFDC for the first time. The added number of people receiving AFDC can be attributed to a change in attitude among recipients as well as organized movements to encourage people to apply for AFDC.

The rural share of total AFDC obligations decreased slightly from twenty-nine percent in fiscal year 1970 to twenty-six percent, approximately $1 billion, in fiscal year 1972. That approximately less assistance goes to rural areas may be attributable to the fact that extended families are more commonly found in rural areas, whereas core families predominate in urban areas. Thus, when a parent becomes absent from a home for one reason or another, the effect is often more severe in the urban setting.

In some States, optional emergency welfare assistance is also available to AFDC recipients and to other families with children who need financial aid during crisis situations. Examples of such aid are payments to providers of services for medical or nonmedical crisis intervention.

There is also a special assistance program for Cuban refugees. This program seeks to aid resettled Cuban refugees with problems such as finding homes, medical care, finding jobs and traveling to reunite with relatives throughout the United States. There are no formula or matching requirements as the program is one-hundred percent Federally funded. A high percentage of this money goes to Florida, especially Miami, since many of the refugees initially settle in that area. This program is being gradually phased out, and the remaining eligibles will be absorbed into regular cash assistance programs.

Child care and welfare services—work incentives program (WIN)

The Work Incentives Program (WIN) utilizes all available manpower services to help develop job-oriented skills for those adults receiving assistance under the aid to Families with Dependent Children program. The Department of Labor (DOL) and the Department of Health, Education and Welfare (DHEW), participate jointly in this program. DOL provides job training, job referral and movement of the family to the job site. HEW makes it possible for eligible adults to receive job training by helping remove some of the obstacles which often makes training difficult.

HEW, through its many and varied social services, provides medical and dental care, eye glasses, prosthetic devices, etc., to adults eligible for AFDC assistance to enable them to partake a job training or job placement. Child day-care services are also provided in cases where the mother is receiving job training and there is no one in the family to care for the children. Family planning and counseling are offered to all female participants in the program. AFDC benefits continue throughout the training and job placement period, however they are discontinued after the participant has completed ninety days of employment.

WIN legislation was intended to make a major impact on those areas where the greatest number of unemployed people and those receiving benefits under the AID to Families with Dependent Children program are located. Most funds are obligated in metropolitan areas.

While there are approximately 327 WIN projects in existence, the top fifty projects receive well over half the funds, and these are in metropolitan areas.

WIN formula grants require at least ten percent State or local funding participation. Obligations for WIN programs have been increasing rapidly. In fiscal year 1970, $15.5 million was obligated. By fiscal year 1972, the amount was $74 million, and fiscal year 1975 obligations are estimated to be $90 million. The rural share of WIN obligations is also increasing. During the period fiscal year 1970 to fiscal year 1972, the rural share increased from 20.2 percent of total obligations to 32.1 percent.

Child welfare services

The Child Welfare Services Program focuses on the problems of child abuse, neglect and dependency. Services provided are for the purpose of preventing or remedying problems which might result in neglect, abuse, exploitation or delinquency of children; caring for homeless, dependent and neglected children; protecting the welfare of children of working mothers; and providing foster home, day care or other child care facilities where the strengthening of the child's own home is not possible.

On a formula grant basis, the Federal Government joins with State governments to establish, extend and strengthen child welfare services. Formula grants may be used for such activities as: costs of personnel to provide protective services to children; standard setting and licensing of private child care agencies and institutions; assistance with expenses for foster care, day care, homemaker services and return or runaway children; and adoptive placements of children.

Each State receives a uniform amount of $70,000 for child welfare services. The balance of the Federal Child Welfare Services appropriation is allotted to States on a variable matching formula which takes into account the population under twenty-one years and the State per capita income. Federal obligations for Child Welfare Services remained steady during the period fiscal year 1970 to 1972 at about $45.8 million. The portion obligated for nonmetropolitan areas increased from $19.7 million to $21 million, or about forty percent of total obligations during this time. The program is currently serving approximately 238,000 families with 430,000 children annually.

Social services

In an effort to alleviate a public welfare recipient's dependency on welfare funds, a formula grant program provides an array of social services which include legal and family planning, housing improvement, child care, and home and money management. States are reimbursed by Federal funds for seventy-five percent of the service costs except for family planning reimbursements which cover ninety percent of their costs.

In 1972, rural areas received twenty-five percent, or $461 million of the $1.8 billion obligated. Since AFDC recipients are the primary beneficiaries of these social services and since only about one-fourth of AFDC recipients are rural residents, it is not surprising that nonmetropolitan areas received only twenty-five percent of the total funds obligated.

Training, research and demonstrations

The Social Security Act, as amended, authorizes a formula grant program that reimburses States for seventy-five percent of their costs in providing training for personnel employed or preparing for employment in State or local agencies administering approved public assistance plans. Rural areas received $11 million, or one-third of the $34 million obligated to this program in 1972.

The Public Assistance Research Program is designed to discover, test, demonstrate, and promote utilization of new social service concepts and service delivery mechanisms which will benefit dependent and vulnerable populations such as the poor, the aged, children and youth. Project grants and contracts are awarded for innovative research and demonstration projects, social services, medical services, and income maintenance. The end objective of the program is to reduce the dependency of public assistance recipients on the Federal government.

Research and demonstration projects may involve day care centers, medicaid management structures, periodic diagnosis and medical treatment, and determination of alternatives in the solution of problems. Projects of specific applicability to rural areas include delivery of public assistance services to rural areas, renovating old homes, and aiding Indians in the consistent receipt of income payments.

Federal funding for Public Assistance Research has been steady at approximately $8 million annually. Data available is insufficient to support a determination of the rural share of program expenditures.

For further information on the programs discussed in the above summary, see OMB, *Catalog of Federal Domestic Assistance*, June 1974.

Income maintenance

13.761 Public Assistance—Maintenance Assistance (State Aid)
13.762 Refugee Assistance—Cuban Refugees

Child care and welfare services

13.707 Child Welfare Services
13.748 Work Incentives Program—Child Care—Employment Related Supportive Services
13.226 Work Incentives Program—Training and Allowances

Social services

13.754. Public Assistance—Social Services

Training, research and demonstrations

13.724 Public Assistance—State and Local Training
13.766 Public Assistance Research

B. MEDICAL ASSISTANCE

Title XIX of the Social Security Act—Medicaid—provides Federal matching payments for State expenditures on health care for the poor. In order to qualify for participation in the Medicaid program, States must meet certain specified Federal requirements which guarantee minimum standards of quality of service as well as equal treatment and access to services for all eligible beneficiaries.

States are required to provide the following basic services in their Title XIX program: in-patient hospital care, out-patient care, skilled nursing facility service and home health services for individuals twenty-one and over, early and periodic screening, diagnosis and treatment services for children under twenty-one, physicians' services, lab and X-ray services, family planning services as well as, by regulation, transportation to medical care where needed. In addition, States may cover optional services: for example, forty-nine States offer prescribed drugs, thirty-six cover eye-glasses, thirty-three finance physical therapy, and forty pay for prosthetic devices. Additionally, Title XIX contains several provisions directed solely to those over sixty-five: payment of Medicare premiums, co-payment and deductible amounts (for cash assistance recipients), and coverage of in-patient hospital services in institutions for mental diseases. Definition and limitations of these benefits vary greatly from State to State. States also have the option of providing any other medical and remedial services recognized under State law.

In fiscal year 1974, fifty-three States and jurisdictions were participating in Medicaid (Arizona is the only State not participating though recent State legislation provides for entry into the program on October 1, 1975). In view of the variations of State standards for eligibility in the categorical public assistance programs, and the fact that Medicaid has no nationally uniform income levels for eligibility, fifty-three States and jurisdictions operate fifty-three different Medicaid programs.

Since the federalization of the adult welfare categories under the Supplementary Security Income Program (SSI), States are no longer required to provide Medicaid services to all adult recipients of cash assistance, as had been the case previously. While they may cover all SSI recipients, alternatively, coverage for the aged, blind, and disabled may be limited by applying any eligibility factor from the January 1, 1972, medical assistance standard which is more restrictive than the conditions of eligibility established for SSI. A State which limits coverage in this manner must, however, deduct medical expenses from income in determining income for those aged, blind, and disabled with incomes above the 1972 standard.

As of January 1, 1974, seventeen States planned to restrict Medicaid eligibility of SSI recipients under this option, and thirty-two States indicated that Medicad coverage would be avalable to all recipients of cash assistance under the Supplementary Security Income program. States also have the option of providing Medicaid coverage to persons receiving a State supplemental payment and may still elect to cover certain medically needy persons who are eligible for help only with their medical bills but do not receive maintenance payments.

Income eligibility levels for the medically needy are tied to cash assistance payment levels and can range from the highest payment standard generally used as a measure of financial eligibility in any of the cash assistance programs to a maximum of 133⅓ percent of the AFDC payment, adjusted for family size. Among the thirty States and jurisdictions with medically needy programs, income eligibility for a family of four ranges from $2,800 in North Carolina to $5,000 in New York State. Of the twenty-three States which do not have programs for the medically indigent, the comparable range in income eligibility varies from $1,248 a year for Alabama, the State with the lowest income standards, to $4,800 in Alaska, the State with the highest income standard.

Matching payments are made to a State as long as the State's plan and operation are in compliance with the requirements of Title XIX of the Social Security Act and Title IV of the Civil Rights Act of 1964. The proportion of Federal matching is based on a Federal medical assistance percentage formula which is computed according to the per capita income of a State. Accordingly, the amount of Federal matching varies from State to State. In terms of the costs incurred by the States to finance Medicaid, the Federal share of the program is fifty-five percent on the average, with the remaining forty-five percent derived from State and local funds. States with large nonmetropolitan populations receive more Federal funds with relatively lower State participation, and States with greater population concentrations in metropolitan areas have greater State participation. Total Federal obligations for the Medicaid program for fiscal year 1972 were close to $4.4 billion dollars, a fifty-six percent increase over the fiscal year 1970 obligations of $2.8 billion. About thirty-seven percent of these totals were used by recipients in nonmetropolitan areas.

Some of the rural States have limited their Medicaid Programs to the minimal required services necessary to obtain Federal financial participation. These limited programs derive from shortage of State fiscal resources as well as the rapidly increasing costs of medical care. Although Medicaid services have begun to make some impact on the health status of the rural poor, there are still significant problems in reaching potential beneficiaries. In particular, eligibles may have to travel long distances to receive services.

For further information on the program discussed in the above summary, see OMB, *Catalog of Federal Domestic Assistance*, June 1974.

13.714 Medical Assistance Program

C. REHABILITATION SERVICES ADMINISTRATION

Rehabilitation Services Administration's (RSA) programs primarily support the State-Federal program of rehabilitation services, special grants and programs relating to mental retardation and other development disabilities, grants for planning and constructing facilities, community service programs, and improving services in State-operated mental retardation facilities. RSA operates under the authority of the Rehabilitation Act of 1973, while its Developmental Disabilities Program draws its authority mainly from the Developmental Disabilities Services and Facilities Construction Amendments of 1970.

Services

The vocational rehabilitation program is a State-Federal joint venture with the State vocational rehabilitation agency acting as the service agency in the delivery of services to individuals who have a physical or mental disability and a substantial handicap. The program is aimed at aiding the handicapped so that they may prepare for and engage in gainful employment. While continuing to provide services to all eligible handicapped individuals, the program's major emphasis is to serve first individuals with the most severe handicaps.

A wide range of services is supported by this program including diagnosis, comprehensive evaluation, counseling, training, braille classes, deaf language classes, and employment placement. The grants may be used for medical treatment, prosthetic and orthotic devices, and transportation to secure vocational rehabilitation services. Necessary tools, licenses, equipment, and supplies may be provided as well as vending stands for the blind. Basic program funds are also used for the establishment and construction of rehabilitation services and facilities. Federal funds for the basic support program are distributed to State vocational rehabilitation agencies on the basis of a State's population weighted by per capita income squared.

A program which provides funding to supplement the basic support program is Rehabilitation Services Projects. These project grants and research contracts are intended to contribute substantially to the solution of vocational rehabilitation problems common to the total physically and mentally handicapped population. Funds may be used for the staffing and improvement of facilities. Projects are awarded on a matching basis ranging from thirty to ninety percent. Rural areas received approximately $9 million of the $58 million obligated in 1972. These figures are estimates, since Rehabilitation Services' money is allocated to each State. Breakdowns beyond the capital county are not available, but are estimated by HEW's Data Management Center according to a predetermined formula.

Similar to the rehabilitation services program is a developmental disability basic support program. These programs differ in two major aspects. First, developmental disability program benefits are limited to those persons who suffer from a neurological disorder which occurred before the age of eighteen, whereas the rehabilitation program covers all individuals with a disability and work potential. The latter program provides services to aid the handicapped person to overcome impediments to employment. The disability program's major goal is directed at the more general objective of alleviating the disabling condition and making the individual more self-sufficient.

The developmentally disabled program allocates its funds on the basis of a prescribed formula covered in the authorizing legislation. In 1972 rural areas received a high share, $9 million, of the $18 million obligated. The large rural share may be attributed to the fact that the developmental disabilities program is relatively new, and States with low populations have been able to more quickly put the program into effect. The more populous States have a larger handicapped group to serve, thus the projects are more complex to implement. It is expected that in successive years the rural share of the program will decrease as the larger States begin to implement projects designed to meet the needs of their disabled persons.

A special program for developmental disabilities provides support for projects that are of national significance. Projects with potential transferability cover new or improved techniques of service delivery, construction, and other special needs including research. Specific projects that have been supported include pre-school demonstrations, a national advisory center for technical assistance, resource data centers, and a national legal center that helps draft legislation and promote class-action suits on behalf of the handicapped.

The Social Security Act, as amended, authorized direct payments to be made for providing vocational rehabilitation services. The services that may be provided include all those authorized under the Rehabilitiation Act of 1973 except for improvements or construction. Social Security trust funds are made available to States based on each State's disability population and with each State receiving a minimum of $25,000.

Training

Two training grant programs seek to increase the numbers of personnel trained to provide vocational services to handicapped individuals. The Rehabilitation Act of 1973 authorizes funds for training directly related to the vocational rehabilitation of the mentally and physically disabled. A second training program provides personnel needed in the rendering of specialized services to persons with developmental disabilities. This program was authorized under the Develmental Disabilities Services and Facilities Construction Act of 1970. Although accurate obligation figures for 1972 are not available, it is estimated that most of the funds are obligated to metropolitan areas since training takes place primarily in urban universities and colleges.

Research

The research grant program supports the study and development of new and innovative approaches to solving rehabilitation problems. The ultimate goal is self-sufficiency, though with the severely disabled it may simply be a greater degree of independence. Project grants and research contracts are made to universities and public and private agencies. Public agencies receive about forty percent of the grants, while universities and private agencies each receive approximately thirty percent of the twenty million dollars obligated annually.

Projects concerned with rural areas include a study of the delivery of rehabilitation services in sparsely populated regions and a demonstration project covering disabled former public assistance recipients living in the Appalachian Region.

For further information on the programs discussed in the above summary, see OMB, *Catalog of Federal Domestic Assistance*, June 1974.

Services

13.746	**Rehabilitation Services and Facilities—Basic Support**
13.747	**Vocational Rehabilitation Services for Social Security Disability Beneficiaries**
13.753	**Development Disabilities—Basic Support**
13.759	**Developmental Disabilities—Special Projects**
13.763	**Rehabilitation Services and Facilities—Special Projects**

Training

13.760	**Developmental Disabilities—Demonstration Facilities and Training**
13.767	**Rehabilitation Training**

Research

13.765	**Rehabilitation Research and Demonstrations**

Chapter VI

SOCIAL SECURITY ADMINISTRATION PROGRAM ANALYSES

The Social Security Administration (SSA) was transferred from the Federal Security Agency as part of the Reorganization Plan I creating the Department of Health, Education and Welfare in 1953. SSA administers a national program of contributory social insurance in which upon the death, retirement or disability of an insured worker, monthly cash benefits are paid to partially replace lost earnings.

In addition, a health insurance program, commonly known as Medicare, is administered by the Social Security Administration with the assistance of private insurance carriers and intermediaries. Financed through separate hospital insurance and supplementary medical insurance trust funds, Medicare provides comprehensive health insurance protection to the aged, long-term disabled, and most persons who need dialysis or kidney transplants because of chronic kidney disease. The hospital insurance part of the program is paid for by payroll contributions from workers, their employers, and the self-employed. The supplementary medical insurance part is a voluntary program paid for premiums from those who enroll and by matching amounts from general revenues.

The latest program to be initiated is the Supplemental Security Income program for the Aged, Blind and Disabled. This program, implemented in January, 1974, is financed out of general revenues and not from social security contributions. The program provides a Federal floor of income for the aged, the blind and the disabled throughout the country. The program is aimed at people in these categories who do not have sufficient income, from all sources, to meet their minimum needs. Since enactment of the Coal Mine Health and Safety Act of 1969, SSA has also administered, and still administers in part, the black lung benefits program which is also financed from general revenues.

A. Social Security Cash Benefits

Retirement and Survivors Insurance

The Social Security program covers over ninety percent of all jobs in the Nation. Of those jobs not covered, about sixty-eight percent are Federal, State, and local civil service employees. Federal civilian employees under a Federal staff-retirement system are excluded from coverage by law. Each State has the option to cover its public workers under Social Security, and about sixty-eight percent of State and local government employees are covered. The remaining thirty-two percent of jobs not covered include self-employed persons whose earnings are less than $400 in a year, domestic workers who do not earn at least $50 a calendar quarter from one employer, clergymen who have elected to be exempted on grounds of religious or conscientious objections, and farm laborers who do not receive $150 from one farm employer during the year or, do not work for pay on a time basis for twenty days or more for one farm employer during the year.

Coverage is available on an optional basis to self-employed farm operators who have earnings from self-employment of less than $400 but whose gross income was at least $600. A similar option is available to non-farm self-employed persons.

Social Security attempts to reach as much of the rural population as possible. Yet in spite of the fact that agricultural workers have been eligible for coverage since 1950, one of the most difficult groups to cover has been the migrant worker. In many cases, the employers of workers who follow the migrant stream are traveling crew leaders, and the workers must depend on the crew leaders to report their earnings for social security credit.

Social Security benefits include retirement, survivors, and disability benefits. Benefits are paid only to persons who are insured, a criterion that is dependent on the number of quarters of coverage on their social security record. A quarter is considered covered if the individual receives at least $50 of wages or is credited with $100 of self-employment income in that quarter. However, a self-employed person must have earnings of $400 or more in a year before he can be credited with quarters of coverage. A farm employee receives credit for one quarter of coverage for each $100 of wages (up to four quarters per year).

Social security benefits are not subject to Federal income tax. The amount of the monthly cash social security benefit that a worker gets, as well as the benefits payable to his dependents or survivors, is determined by the worker's average monthly earnings figured over the period of time he could reasonably have been expected to have worked under social security. The number of years included in the averaging period is generally five less than the number elapsing after 1950 (or age 21, if later) and up to the year of attainment of retirement age, death, or disability. The law includes a provision under which social security benefits in the future will be automaticaly adjusted to increases in the cost of living. Under the law, benefits can be increased automatically each June, beginning with 1975, whenever the cost of living (as measured by the Consumer Price Index) rises by three or more percent between specified base periods. The increase in the Consumer Price Index will generally be measured from the first calendar quarter of a year to the first calendar quarter of the following year.

Since it has not been considered appropriate to cover the full earnings of the most highly-paid people and to pay correspondingly high benefits, there has always been an upper limit (currently $13,200 in 1974) on the amount of a worker's annual earnings on which social security contributions are paid and which is counted for social security benefit purposes. The law provides for adjustments in this amount—referred to as the contribution and benefit base—according to future increase in covered wages.

Retirement benefits are available to insured workers and their spouses at age 62, with the benefits of those who start getting them before age 65 reduced to take account of the longer period over which the benefits will be paid. Effective June 1974, benefit amounts for a man retiring at age 65 in 1974 range from a minimum of $93.80 to a maximum of $304.90 per month, depending on his average monthly earnings over his working lifetime.

To give special recognition to people who work under social security and pay contributions for many years, but whose average monthly earnings—and, therefore, their benefits—are relatively low, the social security law provides for the payment of a special minimum benefit as an alternative to the benefit based on the worker's average monthly earnings under social security in cases where a higher benefit results. The special minimum benefit is equal to $9 for each year of coverage under social security in excess of ten. For workers who retire at age 65 with thirty or more years of coverage, the special minimum is $180 a month.

Based on overall sources of income, Social Security benefits represent approximately thirty-six percent of the income of all individuals over age 65. Payments to beneficiaries in non-metropolitan areas account for about thirty percent of total obligations for Social Security programs. The average per capita benefit is lower than in urban areas, since the average earnings of covered employees in rural areas tend to be lower than in urban areas.

Disability insurance

Disability benefits are paid to workers who are totally disabled, after a waiting period of five full calendar months after the onset of the disability. The benefits are computed in the same way as old-age benefits, but disability payments tend to be larger on the average because the stricter requirements as to previous covered work eliminate irregularly employed workers and those who have had no recent attachment to the labor market, with its attendant higher earning levels. The disability must be so severe that the individual is unable to engage in any kind of substantial work anywhere in the national economy, regardless as to whether such work exists in the immediate area of residence, or whether a specific job vacancy exists for the disabled worker or whether he would be hired if he applied for work. Determinations of disability are made by State agencies (usually the State vocational rehabilitation agencies) under agreements with the Federal Government and on a reimbursable basis.

Approximately forty percent of all disability payments between 1970 and 1972 were made to individuals in rural areas. This is indicative of the fact that the rate of agricultural and industrial accidents is considerably higher in sparsely settled areas where it is much more difficult to enforce industrial safety precautions.

B. SUPPLEMENTAL SECURITY INCOME

Supplemental Security Income (SSI) is a new national program of income maintenance under Title XVI of the Social Security Act, as amended. Implemented in January, 1974, the program provides a nationally-uniform income floor for aged, blind, and disabled persons with limited income and resources. It also encourages those States that have maintained a level of assistance higher than the Federal floor to make supplementary payments to maintain that level for recipients who were on State rolls in December 1973. This Federal program, financed from general funds of the U.S. Treasury, is intended, generally, as a replacement for the former Federal grants to States for old-age assistance, aid to the blind, and aid to the permanently and totally disabled in the fifty States and the District of Columbia.

The Supplemental Security Income program is part of a comprehensive strategy to help the aged, blind, and disabled through a Federal-State partnership. The intent is to allocate to each level of government, Federal and State, those functions it is best able to perform. An important objective of this partnership is an improved system of information, referral, and followup. Federal administration of the program will make possible more efficient and economical operations, and States are able to concentrate on social and rehabilitative services rather than cash assistance.

The basic Federal payment standards for eligible aged, blind and disabled persons as of July, 1974, are $146 for an individual and $219 for a couple with both husband and wife eligible. If an individual or couple is living in another's household and receiving support or maintenance there, the payment standard is reduced by one-third in lieu of counting the actual value of the support and maintenance as income. For persons in institutions, eligibility requirements and benefit standards may vary depending upon the type of institution.

Income must be taken into account in determining payments under the program. However, certain amounts of income are disregarded—on a quarterly basis, $60 of income whether earned or unearned, and $195 of earned income plus one-half of any remaining earned income.

The Social Security Administration interviews new applicants for Supplemental Security Income payments and makes decisions on their eligibility, sets up and maintains a master file of recipients, including newly entitled recipients and people who had been receiving monthly State public assistance payments, makes monthly cash payments to eligible individuals, and refers people to other agencies for services they need.

States supplement the Federal payments, make disability determinations, provide vocational rehabilitation services and other social services, and administer Medicaid.

Total obligations for the categories combined into the SSI program (Old-Age Assistance, Aid to the Blind, Aid to the Permanently and Totally Disabled) in 1970, amounted to $1,973 billion. Between forty-two and fifty-four percent of these funds were received by beneficiaries in rural areas, a reflection of the low earnings base and poor opportunities for employment of the disabled. In fiscal year 1972, the total for these categories had risen to $2,058 billion with a percentage share ranging between thirty-eight and fifty-three. The increase in the estimated SSI obligation of $4.32 billion for fiscal year 1975 over the $2.46 billion for fiscal year 1974 is attributable to the fact that the fiscal year 1974 budget covered only the first half of the fiscal year.

C. Medicare

Medicare is a program of health insurance under social security set up to help millions of Americans sixty-five and older to pay the high cost of health care. Since July 1, 1973, Medicare coverage has also been available to persons under sixty-five who have been entitled to disability benefits for two or more years, or who require dialysis or a kidney transplant because of chronic kidney disease. Medicare has two parts—hospital insurance and medical insurance. The hospital insurance part of Medicare helps pay for a patient's care in a hospital and for certain follow-up care after leaving the hospital. The medical insurance part of Medicare helps pay for doctor's services, out-patient hospital services, and many other medical items and services not covered under hospital insurance.

Hospital insurance

The objective of the Hospital Insurance program is to help those eligible for benefits meet the costs of most services ordinarily furnished in hospitals and of the follow-up care furnished by skilled nursing facilities and home health agencies through a program of prepaid hospital insurance. Excluded from hospital insurance coverage are personal comfort and convenience items, private duty nurses, private rooms unless medically necessary, physicians' services, custodial care, and, in general, services furnished in foreign countries.

All persons sixty-five years or older who are entitled to social security or railroad retirement benefits are automatically covered. Many people who were not eligible for social security or railroad retirement benefits, but who became sixty-five before 1968, qualified for hospital benefits by filing under certain transitional provisions included in the law.

The hospital insurance program is financed by social security deductions paid by employers, employees, and self-employed individuals. These contributions are collected along with regular social security contributions from the wages and self-employment income earned during a person's working years. The contribution rate is 0.9 percent of the first $14,100 of earnings in 1975.

These contributions are put into the Hospital Insurance Trust Fund from which the program's benefits and administrative expenses are paid. Funds from general tax revenues are used to finance hospital insurance benefits for people who are insured under certain special coverage provisions in the initial law even though they are not entitled to monthly social security or railroad retirement benefits. A 1972 change in the law also makes it possible for people sixty-five and over, who are not otherwise entitled to hospital insurance, to enroll in the program and pay premiums into the Hospital Insurance Trust Fund.

In addition, the law provides that various dollar amounts for which the patient is responsible be reviewed annually. These dollar amounts include the first $92 of hospital charges in each benefit period in 1975, and different per-day amounts after certain periods of benefit use in hospitals and skilled nursing facilities. The law also provides that if this annual review shows that hospital costs have changed significantly, these amounts must be adjusted for the following year.

For each benefit period during which a patient is hospitalized, the Hospital Insurance program pays the provider (health institution) the reasonable costs of up to 90 days of inpatient hospital services, 100 days of skilled nursing care, and 100 home health visits. During 1975, beneficiaries are responsible for the first $92 of inpatient hospital care, and $11.50 per day after 20 days of care in a skilled nursing facility for up to 80 additional days. In addition, each Medicare beneficiary may draw upon a lifetime reserve of 60 days of hospital care if the 90 days covered for a benefit period have been exhausted. Beneficiaries pay $46 a day for each day of lifetime reserve used. There is also a lifetime limit of 190 hospital benefit days for care in a psychiatric facility. Other than the above amounts for which the beneficiary is responsible, the program pays the full reasonable costs (including both direct and indirect costs) of covered services.

State health departments determine whether the institution, agencies, and laboratories within the State that wish to participate in the program meet the requirements for participation. State health departments also resurvey participating institutions periodically, consult with them in establishing and maintaining utilization review standards and procedures, and assist them in attempts to improve their services. The Medicare program in turn reimburses State health departments for the costs of performing such services and for a share of the costs of planning the coordination of their Medicare activities with related activities in the health field.

To qualify for participation, an institution must meet certain standards, such as having adequate nursing staff, accessible fire escapes, and other requirements which help to assure safe and high quality care. One important criterion for hospitals participating in the Medicare program is compliance with the Civil Rights Acts, particularly Title VI, which prohibits participating hospitals and skilled nursing facilities from practicing any policy of racial segregation in rendering services. Approximately 95 percent of the licensed general hospitals in the country are certified for participation in the program, but most of those that have not applied or are not certified are primarily located in predominantly rural States. As a result, many aged persons in these areas are denied coverage of hospital care to which they are legally entitled unless they travel to another area which has a participating hospital. The lack of adequate transportation to and from medical services is a major barrier for elderly rural residents as is the lack of skilled medical manpower.

In Fiscal Year 1973, total national expenditures for health and medical care were $80 billion, of which Medicare accounted for 12.5 percent ($10 billion). Of total national health expenditures, 8.6 percent was paid under the hospital insurance program. Of the total national outlays, $30.3 billion was paid from public sources. Medicare represented 29.8 percent of all public spending. About 82 percent of the total spending for hospital care for the aged came from various public sources, and 75 percent of those public expenditures came from Medicare. Approximately 37 percent of Hospital Insurance payments were obligated to nonmetropolitan areas in both FY 1970 and 1972.

Supplementary medical insurance

Supplementary medical insurance, Part B of Medicare, covers physicians' services, out-patient hospital services, medical services and supplies, and out-patient physical therapy. The objective is to help beneficiaries pay bills for physicians' services and certain other medical services and supplies.

Supplementary medical insurance is funded through a voluntary program of medical insurance financed by beneficiary premium payments and matching payments from the Federal Treasury. Benefits are paid for covered services on the basis of reasonable charges. Services and supplies not covered include most out-patient drugs, routine physical checkups, routine foot care, orthopedic shoes, eye examinations and eye glasses, hearing examinations, and hearing aids, immunizations, routine dental care, cosmetic surgery, personal comfort and convenience items, services not reasonable or necessary for diagnosis or treatment, and, in general, services in foreign countries.

All persons sixty-five years or older and eligible disabled persons or kidney disease patients, are eligible for supplementary medical insurance. Persons who wish to enroll are encouraged to notify their local social security office during the three months prior to their sixty-fifth birthday or at the time they apply for Medicare because of disability or severe kidney disease. Beginning July 1, 1974, each enrollee must pay a monthly premium of $6.70. Each year a review of program operations is conducted to insure that full costs are being met. In the future, premiums may be increased only if there has been a general increase in social security cash benefits since the previous premium raise. The increase in the enrollee's share of the premium is limited to the percentage increase in cash benefits.

. After the enrollee meets an annual deductible of $60, the program pays 80 percent of reasonable charges for covered services. "Reasonable charges" are based on the charge customarily made for a given service and the prevailing charges in the same area for a similar service.

The Medicare law mandates that a uniform reimbursement formula be applied throughout the country. Since the formula requires that reimbursement for a given service not exceed prevailing charges in an area, there may be variations from locality to locality within a given State depending upon the level of prevailing charges among physicians. The overall effect of this may be that prevailing charges and reimbursements may vary from State to State.

Total Medicare obligations for fiscal year 1973 amounted to $10 billion. Supplementary medical insurance expenditures amounted to $2.6 billion. Of the total expenditures for physicians' service for the aged, 57 percent came from various public sources. Medicare accounted for 93 percent of these public expenditures. Thirty-seven percent of the obligations for Supplementary Medical Insurance went to beneficiaries in rural areas in both fiscal year 1970 and 1972. Total supplementary medical insurance obligations for the program increased 20 percent during this interval, and hospital insurance obligations increased 38 percent.

D. Special Benefits for Disabled Coal Miners

Of special significance to some non-metropolitan areas are the black lung benefit provisions of the Federal Coal Mine Health and Safety Act, which provides special benefits to coal miners who are totally disabled by pneumoconiosis, often called the black lung disease, and to their dependents or survivors. Pneumoconiosis is a chronic lung disease caused by breathing dust in coal mines. This debilitating disease causes shortness of breath and eventual death. The miner or his survivor must prove that pneumoconiosis is the cause of disability, that it arose from employment in a coal mine and that it prevents the individual from engaging in coal mining work. The applicant may be able to work in areas other than coal mining and still be eligible for benefits.

In FY 1972, $400 million was obligated to eligible beneficiaries of this program, a tremendous increase over the $7.1 million obligated in 1970. Sixty-one percent of the beneficiaries lived in non-metropolitan areas, a slight increase over the fifty-five percent of rural eligibles in 1970. One reason for the increased allowance is a relaxation of the standards of disability related to the disease. Another reason is a better understanding of the symptoms.

For further information on the programs discussed in the above summary, see OMB, *Catalog of Federal Domestic Assistance*, June 1974.

13.800	Medicare—Hospital Insurance
13.801	Medicare—Supplementary Medical Insurance
13.802	Social Security—Disability Insurance
13.803	Social Security—Retirement Insurance
13.804	Social Security—Special Benefits for Persons Aged 72 and over
13.805	Social Security—Survivors Insurance
13.806	Special Benefits for Disabled Coal Miners
13.807	Supplementary Security Income

CHAPTER VII

PROGRAMS JOINTLY FUNDED OR ADMINISTERED BY HEW

A. APPALACHIAN REGIONAL COMMISSION

Appalachia, a nonmetropolitan region which stretches across parts of thirteen States, from southern New York and Ohio to northern Alabama, is an area of intense economic and human need. Income, employment, and educational achievement are considerably below national averages. Infant mortality, illiteracy, and substandard housing are more widespread and concentrated in Appalachia than in any other part of the nation. HEW works with ARC in the area of Human Resource Development. Besides developing its own projects, ARC advocates within HEW to fund additional projects in the region, especially in the categories of vocational education, early childhood development and health.

The Appalachian Regional Commission (ARC) was established in 1965 to utilize resources from the Appalachian States and ten Federal departments and agencies. Two goals were set forth: (1) to provide the people of Appalachia with health and skills they require to compete for opportunity wherever they choose to live; and (2) to develop a self-sustaining Appalachian economy capable of: supporting the people through rising incomes, improving the standard of living, and increasing employment opportunities.

ARC addresses these goals in the following ways. First, working with State and local agencies, ARC develops comprehensive and coordinated plans and programs for the development of the region. Second, financial assistance is provided for implementation of the plans. Third, technical assistance is provided to States and local development districts in furtherance of the program. Fourth, grants and contracts finance research on problems within the region. Finally, the Commission serves as the focal point for coordination of Federal and State efforts in Appalachia.

HEW works with ARC in the area of human resource development. Besides developing its own projects, ARC advocates within HEW to fund additional projects in the region, especially in the categories of vocational and early childhood education and health.

Appalachian health demonstrations

The Appalachian Health Program concentrates on improvement of the quality of health care in the Appalachian region with flexible, noncategorical grants to support multicounty comprehensive health demonstration, areawide comprehensive health planning, and the development and implementation of systems of primary health care. Section 202 of the Appalachian Redevelopment Act authorizes the HEW Secretary (and by delegation, the Public Health Service) to make grants to support the construction of health facilities and the planning and provision of health services.

Responsibility for the program is shared by the Public Health Service, which operates the Health Demonstration Program, and the Appalachian Regional Commission, which sets the broad policies for the Appalachian Regional Development Program. All plans and projects are reviewed by ARC against its economic development criteria and by the PHS Regional Offices against criteria related to technical quality and legality. When both have approved the application, the HEW Regional Office issues the grant award, disburses funds, and administers the grant.

The Federal share of health planning grants may not exceed seventy-five percent of total project cost. Applicants must provide at least twenty percent of construction, renovation, acquisition, or equipment costs. Grants may be made to cover the deficit incurred in operating health services for up to five years, provided that such support may not exceed seventy-five percent of total project costs during the third, fourth, and fifth years. Support may be in combination with grants from other Federal sources, but the total Federal share cannot exceed the maximum allowances established by Section 202 of the Act.

Appalachian child development

The Appalachian Child Development program is designed to create a State-level capability for planning and implementing programs to provide child development services in selected areas throughout the Appalachian region. Planning grants may only be awarded to a State interagency committee designated by each governor. The planning process must include the development of a comprehensive child development plan. Project grants may only be awarded for projects located in the designated demonstration areas. Research and technical assistance grants are also available for those purposes.

The State must provide a twenty percent match for all child development planning programs. Maximum Federal contribution for operating grants is one hundred percent for the first two years for each component facility or service, seventy-five percent for the next three years. Equipment and/or construction projects are limited to a maximum of eighty percent Federal participation. Section 206 of the ARC Code specifically permits health demonstration funds to be used as the local matching share with Social Security Act, Title IV–A (AFDC) and IV–B (Child Welfare Services) funds.

Responsibility for the child development program is shared by HEW and ARC as in the instance of the health demonstration program. The children's program is operated by the Office of Child Development within the Office of the Secretary of HEW.

Supplemental grants

Rural areas often suffer from such chronic unemployment and underemployment that they lack a sufficient tax base to raise the matching funds necessary to qualify for Federal grants. The Appalachian region suffers an additional hardship derived from its special status as a nationally recognized redevelopment area. Because the area is represented by a special quasi-governmental commission authorized to expend special Federal flexible funds within the region for development and demonstration programs, State governments are frequently unwilling to aid local Appalachian communities to meet matching requirements for other categorical Federal programs. The Appalachian portions of the thirteen States which ARC represents are usually not priority areas within their own States; State governments generally assume the ARC will take care of the needs of these local areas.

Recognizing this problem, the Appalachian Regional Commission provides supplemental funds to increase the Federal contribution for projects of construction, land acquisition and/or equipment for eligible applicants who cannot supply the required matching share of the basic Federal program because of their economic situation. ARC also provides special grants where there are insufficient funds available under the basic Federal grant-in-aid program to meet the pressing needs of the region. Under the supplemental grant program, ARC can provide up to thirty percent of the non-Federal portion of project cost. Except for ARC special basic grants, local areas must still contribute some portion of the non-Federal costs.

Funding

In 1972, ARC obligated $35.5 million for health demonstration programs, $17.2 million for child development and $47 million for the supplemental grants program. The Commission estimates that approximately fifty-five percent of supplemental funds were concentrated on the educational and health needs of the region.

No data breakdowns are available on the distribution of these funds to urban and rural areas. Appalachia, which is usually depicted as a vast expanse of used coal mines and barren farmland, is not entirely rural, but also includes many urban communities. The Appalachian Regional Development Act specifies that grants should be made to areas with the greatest potential for development. These areas, known as growth centers and designated by the State, are generally urban and have sufficient population to support services and investments in economic and human resource development in a more cost-effective manner than in rural areas. Precisely because of such areas, the region is able to support projects in urban communities that ultimately impact upon adjacent and more remote rural areas.

For further information on the programs discussed in the above summary, see OMB, *Catalog of Federal Domestic Assistance*, June 1974.

23.002	Appalachian Supplements to Federal Grant-In-Aid
23.004	Appalachian Health Demonstrations
23.013	Appalachian Child Development

B. Comprehensive Employment and Training Act

The Comprehensive Employment and Training Act of 1973 (CETA) provides block grants to State and local governments for development and implementation of comprehensive manpower employment plans. CETA supercedes the Manpower Development Training Act of 1962 (MDTA), Title I of the Economic Opportunity Act of

1964, and the Emergency Employment Act of 1971. These provided categorical funds with no flexibility for adaptation to fit local needs. The intent of the CETA legislation is to enhance the employability of people in an entire labor market area.

The new law incorporates three important principals. First, there is a need to consolidate the many separate contracts in a given area under a single organization called the "prime sponsor." This agency will have overall responsibility for the manpower programs in an area. Secondly, CETA will decategorize manpower programs to free manpower money for use in the ways best suited to a local area. Finally, it will decentralize decision-making responsibility for spending money to the local level, and insure accountability to local citizens by giving the ultimate responsibility to the chief elected official.

Eligible prime sponsors are states, counties, and cities with populations of 100,000 or more. CETA extends eligibility for prime sponsorship to approximately 275 counties and 150 cities in the country. Some of the remaining counties will be joining with eligible prime sponsors to form a multi-county consortium acting as one prime sponsor. The majority of the remaining 2,900 counties, representing about one-third of the nation's population, will become part of the "balance of State" area which will be administered by the governor.

Governors are expected to serve all of the less densely populated areas of each state and provide for an equitable distribution of funds. The law requires the allocation of money to prime sponsors according to a formula based on unemployment, poverty, and previous funding levels. Nevertheless, it does not require a similar breakdown for essentially rural jurisdictions.

The Department of Labor specifically advises the governors not to delegate total operational responsibility for CETA to primarily rural towns and counties. Governors may, however, provide subgrants or contracts to local governments as well as to "service deliverers" of demonstrated effectiveness.

As a prime sponsor, the governor is required to establish a manpower advisory council to assist him in the development of a comprehensive manpower plan. Although the law and the regulations contain language to assure that the council is representative of the area to be served, there is no requirement for a prime sponsor to name rural elected officials to the council.

Flexibility is the most important feature of the Comprehensive Employment and Training Act. A prime sponsor can determine what services are needed and plan programs to meet these needs. Projects can include such activities as an employment service, day-care centers, transportation to jobs or school, vocational training or medical services. Prime sponsors must adhere to only three guidelines: (1) existing services may not be duplicated; (2) projects will enhance the employability of the people being served; and (3) proper administrative and accounting controls must be maintained.

Office of Manpower Coordination

The Office of Manpower Coordination within HEW provides Departmental focus for manpower coordination activities including coordination of the implementation of roles established pursuant to the

Comprehensive Employment and Training Act of 1973. The major goal of the Office is to improve HEW manpower services delivery through coordinated program planning.

The Office has primary responsibility for developing policy, analyzing legislative initiatives and providing staff advice to the Secretary and component agencies in matters relating to the development of comprehensive manpower planning systems. In addition, the Office of Manpower explores methods by which all programs and related activities which are designed to provide for more efficient and economically productive utilization of human resources can be coordinated. The Office evaluates national, State, and local coordination efforts; designs and implements systems for involvement of HEW programs in coordination initiatives; coordinates review of CETA Title III project applications (special manpower target groups—especially Indians, migrants and youth) by constituent HEW agencies; and supports chief officials' comprehensive manpower planning efforts.

Serving in a technical assistance and coordinative capacity, the Office administers no grant funds or projects. Working through a regional manpower coordinator in each of the ten HEW Regional Offices, the Office of Manpower Coordination will assist the Department of Labor in reviewing plans submitted by prime sponsors for CETA activities.

Total funding for the Comprehensive Employment and Training Act is estimated at $2.05 billion for Fiscal 1975. It is too early to estimate the portion that will be allocated to rural balance of state projects.

For further information on the program described in the above summary, see OMB, *Catalog of Federal Domestic Assistance*, June 1974.

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C. Concerted Services in Training and Education

Concerted Services in Training and Education was conceived as a pilot program to improve smaller communities and rural areas through a cooperative Federal, State and local effort. The program goals seek to demonstrate that education and occupational training, together with economic development, can significantly increase employment opportunities; and that educational and occupational training efforts, with local involvement, will develop local leadership and community awareness. The program was initiated when the cabinet-level Rural Development Committee, established under Executive Order 11122, May 1964, recommended that an inter-departmental task force be organized to explore the feasibility of developing CSTE projects in three selected rural areas. By 1973, projects were successfully under way in fifteen states.

Planning and coordination are carried out by an eighteen member task force drawn from the Departments of Health, Education and Welfare, Labor, Agriculture, Commerce, Interior, Housing and Urban Development, the Office of Economic Opportunity, Small Business

Administration and the Regional Commissions. No funds have been specifically requested by an federal agency for the CSTE program. Program support is obtained through regularly appropriated funds made available to specified CSTE areas. In FY 1973, a total of $604.-000 paid local administrative expenses for twenty different CSTE projects, for a project average of $30.200. This federal support is administered through a state agency which is the local project coordinator's employer. The most frequent state employers are the Employment Service, Cooperative Extension Service, and Vocational Education Agency, regardless of the source of federal support.

The major problem that has plagued the program since its beginning has been the lack of a permanent funding source. At various points in the development of Concerted Services, some program funding has been provided by the Departments of Labor, Agriculture, Health, Education and Welfare, the Office of Economic Opportunity, the Appalachian Regional Commission and the Tennessee Valley Authority.

Because of the uncertainties of the annual funding process and the passage of the Comprehensive Employment and Training Act of 1973, Federal level funding in fiscal year 1975 for Concerted Services is received only from the Department of Labor. There are currently fifteen active projects. Two projects were phased out at the end of fiscal year 1975 due to reduced federal funding.

With the passage of the Comprehensive Employment and Training Act, one Inter-Departmental Task Force strategy has been to encourage the establishment of projects throughout the country under the auspices of state or local prime sponsors. This has led to state-level funding of the original demonstration projects, five additional ones in Texas, and to multi-agency state-level funding of the Minnesota Concerted Services project. The Georgia Cooperative Extension Service has continued funding one project in that state through fiscal year 1975. The Task Force Executive Committee has also recommended continuing Federal funding of one demonstration project in each state.

APPENDIX

Table I.—Estimated Population of the United States, 1972: Metropolitan and Nonmetropolitan Populations by State

Table II.—Department of Health, Education and Welfare Obligations to Metropolitan and Nonmetropolitan Areas, Fiscal Year 1972: National Summaries by Administrating Agency

Table III.—(This table [1] is published separately as Volume II of the report.) Department of Health, Education and Welfare Obligations to Metropolitan and Nonmetropolitan Areas, Fiscal Year 1972: State Summaries by Administrating Agency and U.S. Office of Management and Budget.

TABLE I.—ESTIMATED POPULATION OF THE UNITED STATES, 1972: METROPOLITAN AND NONMETROPOLITAN POPULATIONS BY STATE [1]

State	Metropolitan	Nonmetropolitan	Total
Alabama	2, 171, 900	1, 337, 600	3, 509, 500
Alaska	142, 500	184, 600	327, 100
Arizona	1, 440, 000	503, 500	1, 943, 500
Arkansas	756, 200	1, 221, 800	1, 978, 000
California	19, 073, 500	1, 394, 900	20, 468, 400
Colorado	1, 703, 200	654, 500	2, 357, 700
Connecticut	2, 849, 900	231, 900	3, 081, 800
Delaware	393, 800	171, 100	564, 900
District of Columbia	748, 000	0	748, 000
Florida	6, 105, 300	1, 153, 500	7, 258, 800
Georgia	2, 672, 800	2, 047, 200	4, 720, 000
Hawaii	660, 100	148, 400	808, 500
Idaho	120, 200	635, 700	755, 900
Illinois	9, 073, 300	2, 177, 200	11, 250, 500
Indiana	3, 408, 800	1, 882, 000	5, 290, 800
Iowa	1, 061, 800	1, 820, 600	2, 882, 400
Kansas	976, 900	1, 281, 500	2, 258, 400
Kentucky	1, 535, 000	1, 764, 500	3, 299, 500
Louisiana	2, 322, 100	1, 398, 800	3, 720, 900
Maine	314, 900	714, 100	1, 029, 000
Maryland	3, 472, 500	583, 800	4, 056, 300
Massachusetts	5, 611, 100	175, 900	5, 787, 000
Michigan	7, 473, 700	1, 608, 400	9, 082, 100
Minnesota	2, 458, 100	1, 438, 100	3, 896, 200
Mississippi	472, 400	1, 791, 300	2, 263, 700
Missouri	2, 529, 600	1, 688, 700	4, 218, 300
Montana	177, 100	541, 900	719, 000
Nebraska	670, 700	854, 300	1, 525, 000
Nevada	426, 300	101, 100	527, 400
New Hampshire	383, 700	387, 900	771, 600
New Jersey	6, 898, 500	468, 100	7, 366, 600
New Mexico	356, 900	708, 500	1, 065, 400
New York	16, 147, 200	2, 020, 900	18, 168, 100
North Carolina	2, 355, 400	2, 858, 300	5, 213, 700
North Dakota	77, 300	554, 500	631, 800
Ohio	8, 671, 600	2, 111, 600	10, 783, 200
Oklahoma	1, 455, 000	1, 178, 200	2, 633, 200
Oregon	1, 317, 200	864, 200	2, 181, 400

Footnote at end of table.

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[1] Information concerning table III can be obtained from the Senate Committee on Agriculture & Forestry, Room 322 Russell Senate Office Bldg.

TABLE I.—ESTIMATED POPULATION OF THE UNITED STATES, 1972: METROPOLITAN AND NONMETROPOLITAN POPULATIONS BY STATE [1]—Continued

State	Metropolitan	Nonmetropolitan	Total
Pennsylvania	9, 656. 700	2, 269, 800	11, 926, 500
Rhode Island	872, 300	95, 800	968, 100
South Carolina	1, 266, 600	1, 399, 100	2, 665, 700
South Dakota	96, 700	581, 800	678, 500
Tennessee	2, 416, 200	1, 614, 600	4, 030, 800
Texas	8, 953, 500	2, 696, 000	11, 649, 500
Utah	893, 900	231, 500	1, 125, 400
Vermont	0	459, 900	459, 900
Virginia	3, 128, 400	1, 635, 600	4, 764, 000
Washington	2, 491, 000	952, 700	3, 443, 700
West Virginia	666, 300	1, 114, 900	1, 781, 200
Wisconsin	2, 628, 000	1, 891, 900	4, 519, 900
Wyoming	0	344, 700	344, 700
Total, United States	151, 554, 100	55, 947, 400	207, 501, 500
Percent	73	27	100

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[1] For the purposes of this table, metropolitan is defined as the population of a county containing a city of 50,000 people or more. This is not the same definition used in tables II and III. That definition includes the above but adds that the county has a population density of 100 persons per square mile or more.

Source: USDA Economic Research Service based on Bureau of the Census estimated 1972 population.

TABLE II.—DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE OBLIGATIONS TO METROPOLITAN AND NONMETROPOLITAN AREAS, FISCAL YEAR 1972:[1] NATIONAL SUMMARIES BY ADMINISTRATING AGENCY

[Numbers other than percentages are in thousands]

	Nonmetropolitan areas	Percentage of total	Metropolitan areas	Percentage of total	DHEW total
Food and Drug Administration	982	1. 3	74, 211	98. 7	75, 193
Health Services and Mental Health Administration	407, 462	27. 0	1, 100, 737	73. 0	1, 508, 199
National Institutes of Health	179, 498	9. 9	1, 641, 159	90. 1	1, 820, 657
Office of Education	1, 507, 470	30. 6	3, 424, 127	69. 4	4, 931, 597
Office of the Secretary	144, 609	44. 9	177, 698	55. 1	322, 307
Social and Rehabilitation Service	4, 502, 163	33. 7	8, 859, 034	66. 3	13, 361, 197
Social Security Administration	17, 960, 114	37. 2	30, 294, 655	62. 8	48, 254, 769
Special institutions	0	0	134, 988	100. 0	134, 988
Total	24, 702, 298	35. 08	45, 706, 609	64. 9	70, 408, 907

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[1] Summarized from table III, State data tables found in vol. II of this report.